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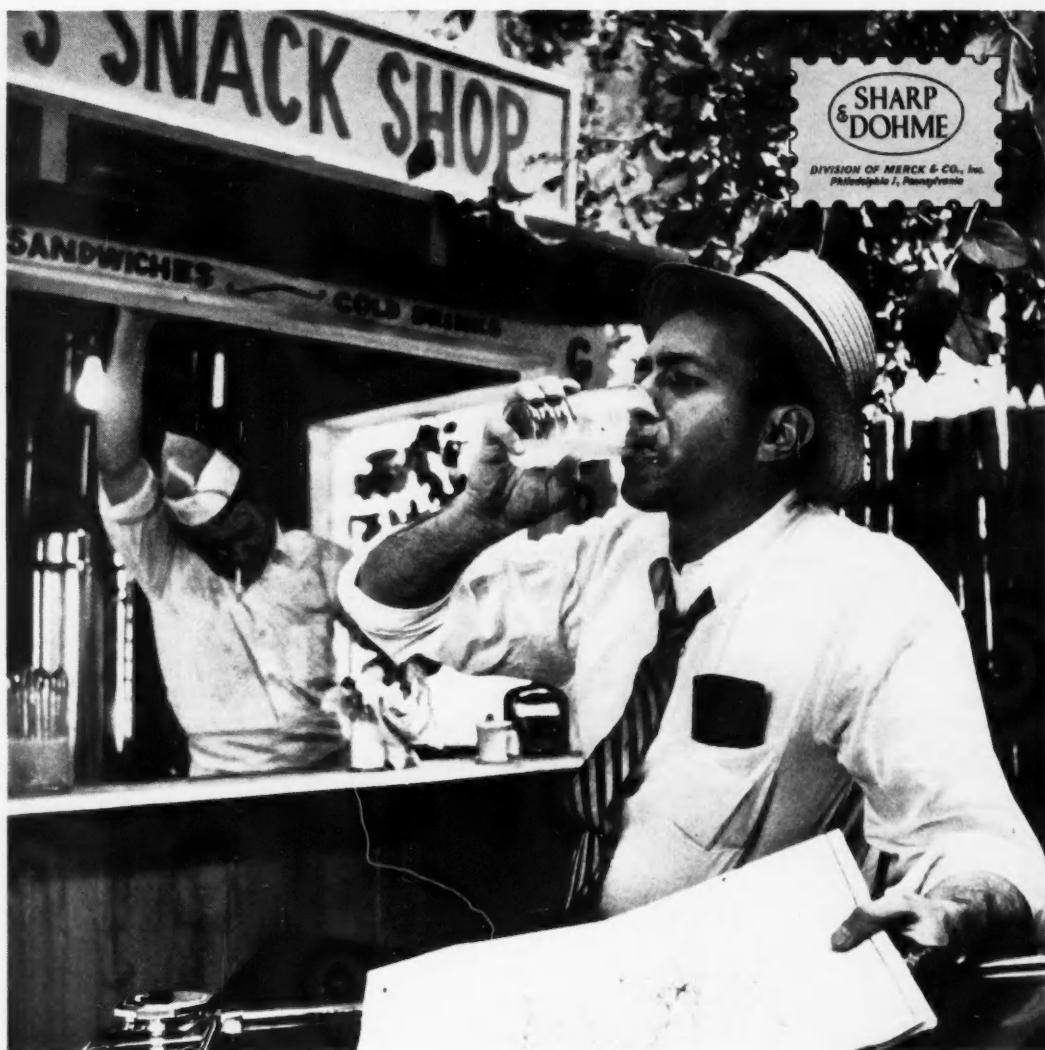
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Spinal Puncture Headache

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HEADACHE is probably the most common untoward complication of spinal puncture. August Bier suffered a severe headache following his submission to the first attempt to produce spinal anesthesia in man in 1898. The incidence of headache following spinal puncture seems to vary little whether or not the puncture is followed by the injection of an anesthetic agent. Babcock,⁵ in 1913, reported an incidence of headache of 21 per cent in 5,000 cases. Koster and Weintrob,²⁵ in 1930, reported postspinal puncture headache in 10 per cent of 6,000 patients who received spinal anesthesia. Woodbridge,⁴³ in 1937, reported a 4 per cent incidence of spinal puncture headache in 1,381 patients. Jennings²¹ reported 30.6 per cent in 1939, while Hingson, Ferguson and Palmer,¹⁹ in 1943, reported an incidence of only 1 per cent in 5,150 cases. Although there is wide variation in the reported incidence of headache following spinal puncture, the majority of the recent reports indicate that the incidence is probably between 10 and 20 per cent.^{2, 4, 10, 12, 15, 39, 40}

Recently the authors made a study of a series of 515 consecutive cases in which spinal anesthesia was employed, with the idea of determining the incidence of spinal puncture headache. No attempt was made to direct the patient's attention away from the possibility of headache following anesthesia. In fact, each patient was told that headache was a common sequel

• Headache is the commonest complication of spinal puncture. There is no significant difference in the incidence of headache after lumbar puncture, whether or not the puncture is followed by injection of an anesthetic agent. The sequence of events leading to postlumbar puncture headaches is probably (1) decreased volume of cerebrospinal fluid with lowered pressure; (2) increased differential between the pressure of the cerebrospinal fluid and the intracranial venous pressure; (3) dilation of venous structures with increase in brain volume; and (4) production of tension on the pain sensitive areas in the cranium.

Prevention of postlumbar puncture headache consists largely in attempts to avoid the development of the pressure differential between that of the cerebrospinal fluid and intracranial venous pressure. Treatment consists of analgesics, hydration and attempts to restore normal cerebrospinal fluid pressure.

of spinal puncture. Each was then asked specifically if he did have a headache after operation. Even though the question was "leading," the answers obtained indicated that the incidence was almost the same as that commonly reported. Furthermore, contrary to a previous assumption, early ambulation after operation apparently did not materially increase the number of postspinal puncture headaches. There seemed to be an appreciably greater incidence of postpunc-

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Address of a Guest Speaker, presented before the General Meeting at the 83rd Annual Session of the California Medical Association, Los Angeles, May 9-13, 1954.

TABLE 1.—Headache following spinal anesthesia

Type	Number	—Postspinal headaches—		—Other headaches—		—All headaches—	
		Number	Per cent	Number	Per cent	Number	Per cent
Spinal	291	17	5.8	8	2.7	25	8.6
Continuous spinal.....	224	21	9.4	10	4.5	31	13.9
Total	515	38	7.4	18	3.5	56	10.8

ture headaches, however, when the agent was administered by the continuous or fractional technique (Table 1).

Not all headaches complained of following a spinal puncture can be considered to be postpuncture headaches. Headaches unaffected by postural changes and described by the patient as similar to those they have been subject to were not considered to be true postspinal puncture headaches. In the present series the final judgment as to whether the discomfort was a new development or merely the recurrence of a chronic malady was left to the patient.

For many years postspinal puncture headache has been considered to be related to changes in cerebrospinal hydrodynamics. Most observers have ascribed these headaches to lowered intracranial pressure,^{2, 20, 28, 29, 33, 37, 42} although a few have noted that they may be associated with increased pressure.^{17, 23}

With the patient in the horizontal position, intracranial (vertex) pressure is usually the same as lumbar and cisternal pressure. Intracranial pressure usually varies from 50 to 180 mm. of mercury. With the patient erect, lumbar pressure may be as high as 300 to 500 mm. of mercury while the intracranial pressure may drop to +40 or even to -85 mm. of pressure. On occasions it may even reach -300 mm. of mercury.⁴² Changes in cerebrospinal fluid pressure probably closely parallel changes in venous pressure in the normal subject, although the cerebrospinal fluid pressure is usually somewhat higher than the venous pressure at any given level.

Wolff⁴² demonstrated that there are certain sensitive structures in the cranium the stimulation of which will produce pain. The pain produced by the stimulation of these regions may be interpreted by the subject as headache. Demonstration of these pain-sensitive areas was carried out on human beings undergoing intracranial surgical procedures under local anesthesia. The principal structures found to be pain-sensitive are: (1) the great venous sinuses, (2) the venous tributaries to the sinuses, (3) parts of the dura near the base of the brain, (4) dural arteries and (5) cerebral arteries at the base of the brain. The afferent nerve pathways for pain from these areas are by way of the fifth nerve for all those structures above the tentorium, while subtentorial pain is transmitted largely through the ninth and tenth nerves. Some of the pain, low in the subocciput, possibly is transmitted by the upper cervical nerves.

Pain caused by stimulation of pain-sensitive areas above the tentorium is referred to the head anterior to the ears and in the region of the eyes, while pain posterior to the ears and in the subocciput is probably from stimulation of sensitive areas below the tentorium.

Drainage headache is a well established clinical entity. The universal complaint of headache, usually very severe, during the course of encephalography under local anesthesia is evidence of the syndrome of drainage headache. It is a common observation that headache of this kind develops quite early in the procedure when only a small amount of fluid has been removed. Wolff⁴² produced headache experimentally in 11 subjects by the drainage of cerebrospinal fluid and found that headache developed usually when about 20 cc. of fluid had been removed. The headache became worse as more fluid was withdrawn and could be relieved in all subjects by restoring the cerebrospinal fluid pressure to its previous value. These experimentally produced drainage headaches as well as the headache that is a sequel to encephalography are in every way comparable to the headache that may follow spinal anesthesia or diagnostic lumbar puncture. Wolff stated that headache probably will start when approximately 10 per cent of the estimated total volume of cerebrospinal fluid is removed.

Although the overwhelming majority of the evidence seems to favor the hypothesis that the most important factor in the production of postlumbar puncture headache is the lowering of the cerebrospinal fluid pressure, other possible contributing factors must be considered.

Irritation of the pia-arachnoid by the anesthetic agent has been suggested as a possible cause of postspinal anesthetic headache. This seems unlikely, considering the very high dilution of the agent in the cerebrospinal fluid and the usual lack of a significant rise in protein content and cell count of the cerebrospinal fluid following spinal anesthesia.^{6, 8, 24} At operations involving opening of the dura following spinal anesthesia, seldom is any evidence of dural or meningeal irritation observed. Furthermore, the incidence of headache following diagnostic lumbar puncture is usually reported as high as that following spinal anesthesia.

Meningitis undoubtedly can cause severe headache, but only on very rare occasions could this be considered a cause of postpuncture headache. Other

symptoms of meningitis would probably be so evident as to leave little doubt as to whether this was the principal etiologic factor in a particular case.

Weintraub, Antine and Raphael⁴⁰ suggested that the decrease in intra-abdominal pressure after delivery is an important factor in the production of post-puncture headache when spinal anesthesia is used in obstetrics. They postulated that the pooling of the blood in the splanchnic vessels after the sudden release of intra-abdominal pressure lowers the pressure in the intracranial veins, permitting the brain to sag as some of its basilar cushion is lost. They advocated the use of tight abdominal binders as an aid in the correction of this imbalance in the intracranial circulation. They expressed belief that the increased return of blood following abdominal compression increases the pressure in the right auricle, which is transmitted by the jugular veins to the cerebral vessels. A possible additional mechanism whereby tight abdominal binders might contribute to restoration of proper balance to the intracranial circulation is suggested by the work of Batson.⁷ He demonstrated that the current of the flow of blood in the vertebral plexus of veins can be reversed by increased intra-abdominal pressure.

Although there is experimental evidence to the effect that even pronounced increase in intracranial pressure usually does not cause headache,⁴² certain clinical observations seem to indicate that at times increased intracranial pressure may be a factor in the production of headache. Hand¹⁷ observed that some patients in whom headache developed incidental to repeated subarachnoid injections of ammonium sulfate for the relief of intractable pain had increased intracranial pressure. It is not uncommon for patients to complain of transitory headache occurring at the time of injection of the spinal anesthetic agent when large volumes (10 to 20 cc.), such as are used with the Howard-Jones technique for Nupercaine, are employed.

In spite of the fact that other factors may be present and at times contribute to postspinal puncture headache, it must be concluded that in most instances this complication is related to a lowering of the cerebrospinal fluid pressure owing to a reduced volume of fluid. Obviously, this decrease in cerebrospinal fluid volume could be caused by a decrease in the fluid output or by leakage of the fluid after it is formed. There seems little doubt that it is the result of leakage through the hole left in the dura by the spinal puncture needle. There is ample evidence that this hole remains for several days after spinal puncture.^{2, 13, 32, 34} Mixer³² noted that the hole made by the spinal needle in the dura was present at operation six days after spinal puncture. Franksson and Gordh¹² observed the hole still patent as late as 14 days after spinal puncture. The negative

pressure reported to exist in the epidural space could be a factor contributing to the lowering of cerebrospinal fluid volume because of a hole in the dura. The incidence of failure in attempts to produce spinal anesthesia within the first few days after spinal puncture is notoriously high. In one case observed by the authors, three successive unsuccessful attempts were made to induce spinal anesthesia for the removal of a ruptured intervertebral disk. The anesthetic agent was given approximately 48 hours after myelography. Even though a free flow of cerebrospinal fluid was obtained with each attempt, no more than a few scattered areas of patchy anesthesia in the thighs and lower trunk could be induced. General anesthesia was induced, and at operation a large collection of epidural fluid was noted, and it was observed that the anterior and posterior walls of the dura were practically in apposition. Undoubtedly it was into this fluid-containing epidural space that the anesthetic agent was injected.

Further evidence that lowering of cerebrospinal fluid pressure is the prime etiologic factor in the production of postspinal puncture headache is the fact that measures which restore the volume of cerebrospinal fluid tend to relieve the headache. Injection of normal saline solution into the subarachnoid space is always followed by relief.² The intravenous injection of hypotonic solution is reported^{3, 37} to be helpful. On the other hand, hypertonic solutions given intravenously tend to increase the symptoms.³⁰

The intensity of postspinal puncture headache is increased by bilateral jugular compression. This occurs in spite of the well known fact that this procedure is accompanied by a substantial rise in cerebrospinal fluid pressure. Jugular compression, in addition to causing a secondary rise in cerebrospinal fluid pressure, results in an earlier primary rise in intracranial venous pressure. This increase in symptoms with jugular compression undoubtedly is the result of stimulation of the pain-sensitive areas by distention of veins and perhaps by an increase in volume of the brain. This increase in symptoms from jugular compression is difficult to reconcile with the benefits derived from the use of tight abdominal binders, reported by Weintraub, Antine and Raphael.⁴⁰

It seems likely that postspinal puncture headache is caused by the stimulation of the pain-sensitive areas in the cranium that are concerned with anchoring the brain to the cranial vault. The chain of events leading to stimulation of these pain-sensitive areas may be as follows: (1) lowering of the cerebrospinal fluid pressure due to decreased volume, (2) production of a greater differential between the cerebrospinal fluid pressure and the intracranial venous pressure, bringing about (3) dilation of the venous structures and perhaps some increase in brain volume because of the venous dilation and edema.

What are the characteristic features of drainage or postspinal puncture headache? The headache occurs as a sequel to spinal puncture at varying intervals, from a few hours to several days. The headache may be mild but is frequently a dull, deep ache. It is usually not, but on occasions may be, throbbing. It is more often frontal but may be occipital, suboccipital or bitemporal. A small proportion of patients complain of pain or stiffness at the nape of the neck.

Characteristics of postspinal puncture headache which would seem to indicate that it is due to stimulation of the pain-sensitive areas as a result of lowering of cerebrospinal fluid pressure are: (1) the headache is relieved by intraspinal injection of physiologic saline solution in amounts sufficient to restore spinal fluid volume, (2) the headache is more severe when the patient is in the erect position, (3) it is usually relieved or made much milder when the horizontal position is assumed, (4) shaking of the head increases the severity of the headache and (5) the headache is made worse by jugular compression.

PREVENTION

Although it is difficult to evaluate the benefits of each measure designed to decrease the incidence of postspinal puncture headache, other than the obvious one of using some other kind of anesthesia, the adoption of certain measures would seem reasonable, even though it cannot be said that strict adherence to any one or all of them will prevent postspinal puncture headache.

It is well known that anyone's reaction to discomfort related to the head is in no way different from his reaction to pain in other parts of the body. It is probably wise to select some other form of anesthesia for patients who have a history of severe headaches or who are obviously likely to react poorly to pain of any type. Furthermore, except for very unusual reasons, spinal anesthesia should not be selected for patients who have a history of headache following a previous spinal puncture. However, the authors' investigations indicated that the history of a headache following spinal anesthesia does not mean that subsequent spinal anesthesia will necessarily be followed by a headache. Conversely, freedom from headache after one spinal puncture is not a guarantee of permanent immunity.

Anything that tends to reduce the leakage of spinal fluid from the subarachnoid space after spinal puncture would be expected to decrease the incidence of spinal puncture headache. There has been a tendency to use smaller and smaller spinal puncture needles. Cann and Wycoff⁹ reported upon a series in which a 27 gauge needle was used for spinal anesthesia in an attempt to reduce the number of cases of postspinal puncture headache. The incidence of headaches with this small needle was approximately 5

per cent. Greene¹⁵ (1949) reported a decrease in the incidence of headache following spinal anesthesia employed for vaginal delivery when he changed from a 22 gauge to a 24 gauge needle. More recently¹⁴ (1950) he advocated the use of a 26 gauge needle and noted a decrease in the incidence of postspinal headache from 22 per cent to 0.4 per cent in 700 patients. Recently Whitacre⁴¹ advocated the use of a needle with a point resembling that of a pencil. This needle is designed to separate dural fibers rather than sever them. He reported a significant decrease in the incidence of postspinal headache when this needle was used. Maxson³¹ suggested that the bevel of the needle should be parallel with the long axis of the body so that there will be a tendency to separate fibers of the dura rather than to cut them in two. Franksson and Gordh¹² counted dural fibers severed with the needle point and noted fewer fibers cut when the bevel was held parallel to the long axis of the patient.

If the patient is held very quiet during the spinal puncture the danger of a dural tear is probably lessened. The approximately 50 per cent greater incidence of headache in the present series when the continuous technique was employed (Table 1) would seem to lend support to this assumption. It seems likely that movements of the vertebral column incidental to turning the patient into position with a needle in the subdural space would tend to enlarge the dural opening. Furthermore, an increased incidence of postpuncture headache might be expected if more than one puncture is made.

The insistence that patients be kept in the horizontal position without a pillow for a given length of time after operation probably is of little value in the prevention of postpuncture headaches.¹ Apparently the patient who will develop a headache following spinal puncture will do so irrespective of whether or not he is kept flat in bed for 24 to 48 hours following spinal puncture. This is understandable in light of the long time the opening made in the dura by the spinal needle remains patent.

Kaplan and Arrowood²² reported a significant decrease in the incidence of postspinal headache when they injected 10 to 20 cc. of physiologic saline solution into the epidural space immediately following the injection of the anesthetic agent. After the agent was injected they merely withdrew the spinal puncture needle until the point was in the epidural space, then injected the saline solution before removing the needle. They explained this benefit on the theory that a head of pressure in the epidural spaces prevents leakage until the hole can be sealed by a fibrin clot or by the pia-arachnoid.

Increased fluid intake following spinal puncture might be expected to be of both prophylactic and therapeutic value. Recently the authors instituted the practice of administering intravenously 1,000 cc. of

5 per cent dextrose in water to all patients receiving spinal anesthesia except when such a procedure is contraindicated for some medical reason. This is started in the operating room and is done regardless of how minor the surgical procedure. Although sufficient data are not as yet available, the impression thus far is that the incidence of postspinal puncture headaches has been materially decreased since this regimen has been followed.

TREATMENT OF POSTPUNCTURE HEADACHE

The treatment of this most distressing complication still leaves much to be desired. Fortunately, most postspinal puncture headaches are mild and respond well to ordinary analgesics, such as aspirin.

Pituitrin has been used both prophylactically and therapeutically for postspinal puncture headache, probably with the idea of decreasing fluid excretion, but its value is questionable.^{3, 15, 32, 33, 37} Caffeine sodium benzoate has been used more or less empirically for years. The effectiveness of this drug is likewise doubtful.

Deutsch¹¹ reported encouraging results following intravenous infusion of 5 per cent ethyl alcohol in 5 per cent dextrose in distilled water. A total of 1,000 cc. of solution was given in three and a half to four hours. Deutsch sometimes found it necessary to give a second infusion. This treatment is aimed at dilatation of the vessels of the choroid plexus and at the same time supplying a hypotonic solution to enter into the formation of cerebrospinal fluid.

Krueger, Stoelting and Graf²⁶ used 500 to 1,000 cc. of 5 per cent dextrose in .45 per cent sodium chloride to which was added 100 mg. of nicotinic acid, given intravenously, on the same basis, also with beneficial results.

Targowla and Lamache,³⁸ in 1927, mentioned the use of ergotamine in the treatment of spinal puncture headaches. Guttman¹⁶ reported the drug gave complete relief in 82 per cent of patients with post-puncture headaches. Lennox, von Storch and Solomon,²⁷ however, stated that it was of no value in the treatment of drainage headache.

True postspinal puncture or drainage headache can always be greatly relieved and usually completely eliminated by placing the patient in the horizontal position. This may be quite objectionable to a patient who has had a spinal anesthetic for a relatively minor surgical procedure and, except for the headache, has little if any discomfort. Sometimes it may be helpful to resume the erect position gradually once the headache has been relieved by assuming the horizontal position. To do this, the bed can be turned up in stages, with several minutes or even hours taken to change from horizontal to completely erect.

The more intractable postspinal puncture headache should be investigated carefully. A lumbar puncture should be performed and the pressure of cerebrospinal fluid determined. Chemical, microscopic and bacteriologic investigations should be carried out. This is particularly applicable in cases of persistent headache unaffected by postural changes.

As with experimental drainage headache, postspinal puncture headache can always be relieved by injection of physiologic saline solution to restore the pressure of the cerebrospinal fluid. To subject a patient with postspinal puncture headache to another spinal puncture requires courage both on the part of the patient and of the physician. Although it would seem that only transitory relief might be expected from the restoration of spinal fluid pressure to normal by the subarachnoid injection of physiologic saline solution, this relief may be permanent after a single injection. If it is not, the procedure may be repeated and the relief may be permanent after the second or third injection.

Rice and Dabbs³⁵ reported that by peridural injections of saline solution they obtained relief of postpuncture headache in 21 of 22 patients. They demonstrated that the epidural injection of saline solution produced a prompt rise of as much as 100 mm. of pressure in the subarachnoid space. The rise in cerebrospinal fluid pressure and relief of headache was attributed to a "splinting" effect of the epidural fluid. From observations in a few cases in which the authors have used this method it seems to be very worth while. It has the obvious advantage over subarachnoid injection of saline solution of not requiring a second puncturing of the dura.

The use of abdominal binders for the relief of spinal puncture headache may be helpful particularly if the headache has developed after the use of spinal anesthesia for delivery.⁴⁰

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Treatment of Carcinoma of the Uterine Cervix*

A Commentary on Current Methods

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SEVERAL DISQUIETING STATEMENTS in the recent American Cancer Society monograph on Cancer of the Female Genital Tract¹ warrant further discussion.

First, the suggestion that operation with conservation of the ovaries is the treatment of choice "if the lesion is small and the patient is young, i.e., less than 35 years" should be more fully explained. This approach is widely accepted in proven cases of carcinoma *in situ*. However, it is probable that to most readers of this monograph, the words "small" and "early" with reference to carcinoma of the cervix imply a lesion of the clinical Stage I type. The ever-increasing tendency to stress the surgical approach in so-called early carcinoma of the cervix receives a stimulation that surely is not the intent of the authors. It is quite generally recognized that regardless of the trends of preference in any hospital or clinic, be they toward operation or irradiation, both forms of treatment should be available. Indeed, following a competent unbiased appraisal of the patient and the cancer, one patient with an early lesion will be advised to have operation, while for the next patient with a similar lesion radiation will be recommended.

Second, the suggestion in the monograph that the scope of the surgical excision be determined on the basis of frozen section examination of the obturator and iliac nodes implies a competency of tissue evaluation difficult to accept. Limiting immediate examination to these two groups of nodes seems to neglect the possibility of metastatic involvement elsewhere. Next to the paracervical (ureteric) and the small parametric nodes, the obturator and the iliac groups are most frequently involved. However, bypassing of these two groups with involvement of the nodes of the hypogastric or sacral groups occurs frequently enough to be considered of major importance. In material observed by the author, involve-

* A monograph on Cancer of the Female Genital Tract published by the American Cancer Society seems to put greater than warranted stress on the value of operative treatment as compared with radiotherapy of "small" or "early" lesions of the uterine cervix. The terms themselves may be misleading in that many readers may mistakenly take them to mean Stage I lesions. A diagnosis of Stage I is no assurance that extension has not occurred (as it had in 23.5 per cent of 17 cases of Stage I carcinoma observed by the author).

In addition, there is suggestion in the monograph that the extent of operation may be reliably determined on the basis of frozen section examination of the obturator and iliac nodes. This overlooks the considerable possibility of metastasis that skips these groups and extends to others beyond (as it did in one of the 17 cases).

Moreover, preoperative diagnosis of the stage of a lesion is not wholly reliable. In a series of 37 cases observed by the author in which the preoperative diagnosis was Stage I carcinoma of the cervix, pathological examination of tissues, after total hysterectomy of the Wertheim type, revealed that in nine cases the growth was actually at a more advanced stage. Upon further examination of tissues it was noted also that the excision was inadequate in 33 of the 37 cases.

ment of nodes was noted at autopsy in four of 17 untreated patients (23.5 per cent) with Stage I carcinoma of the cervix. If a fifth case in which there was involvement of two positive small anomalous nodes in the subvesical space were included, the incidence of nodal involvement in the 17 cases of proven Stage I carcinoma of the cervix would be 29.3 per cent. In two of the four cases with "positive" regional nodes, the obturator group was involved; in another the obturator and external iliac, and in the fourth the left lateral sacral group. It is of further interest that the involvement in the "positive" nodes was overlooked in two of the four cases when the study was limited to three blocks of each node. Not until re-study was

*This commentary has been prepared, at the request of the Cancer Commission of the California Medical Association, by a member of the Commission particularly qualified by wide experience in gynecologic surgery and by original investigational studies of uterine cancer.

The Cancer Commission and its Advisory Committee are in unanimous disagreement (see page 97 of this issue of CALIFORNIA MEDICINE) with some of the therapeutic implications in the widely distributed monograph¹ referred to in the text. In particular, the Commission believes that the emphasis on surgical treatment of carcinoma of the cervix is ill-advised. From the standpoints of wider applicability, lesser morbidity, and better over-all end results, radiation therapy is superior to operation in the majority of patients with this form of cancer.

carried out with five blocks was the nodal involvement noted. It is certainly within the realm of reason that if a more thorough examination of each node were carried out in such cases, the observed incidence of involvement would be greater. Hence, the proposal that the presence or absence of malignant emboli in a node can be detected consistently by a hurried frozen section examination is certainly most questionable.

Of further interest is the matter of establishing the true clinical status of the disease before operation or necropsy. In a series observed by the author, a study was made of tissue and organs in 37 cases in which the diagnosis was Stage I cancer of the cervix and the treatment was the Wertheim type of total hysterectomy and lymphadenectomy. The following data were obtained: In eight of the 37 cases (21.5 per cent) the growth was considered Stage II and in one case (2.7 per cent) Stage III. Thus, in 24 per cent of the 37 cases in which thorough and competent preoperative examinations were carried out, the lesion was found to be in a more advanced stage than had been diagnosed. Further examination of the organs and tissues revealed inadequate excision

in 33 (89 per cent) of the cases. These observations are both disturbing and discouraging in the assay of the various ideas of what constitutes radical operation for carcinoma of the cervix. Certainly no half-way measure is conscionable. Since the possibility of unsuspected extension is always present, if operation is to be done at all it should be adequate.

Recognizing that the Cancer Society's monograph is mailed to some 65,000 physicians and possibly is accepted as the final word by a large number, the author believes stress should have been put on the value of irradiation, except in the occasional cases in which the growth is radio-resistant. To stress the value or superiority of an approach that possibly has proven worthwhile in the hands of a very competent gynecological surgeon in a highly organized clinic disregards the tendency of too many self-admitted competent surgeons to accept this *modus operandi* as the final answer.

1136 West Sixth Street.

REFERENCE

I. Traut, H. F., and Benson, R. C.: Cancer of the Female Genital Tract, American Cancer Society, Inc., New York, N. Y., 1954.

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As your personal physician I consider it both a privilege and a matter of duty to be available in case of an emergency. But, being only human you can understand that there are times when I may not be on call. I might be at a medical meeting outside the city, on a bit of a vacation—or even ill.

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Isoniazid Therapy in Chronic Ulcerative Colitis

A Preliminary Report

DAVID A. SUSNOW, M.D., San Francisco

MANY DRUGS and forms of treatment have been proposed for dealing with chronic ulcerative colitis, and some of them, while appearing to help in some cases, fail in the great majority. Nevertheless any drug which seems to be of aid should be investigated as to its possibilities.

So far as could be determined, isoniazid (isonicotinic acid hydrazide) has not been used in chronic ulcerative colitis. Favorable results with the drug have been noted¹ in nonpulmonary tuberculous lesions such as draining sinuses and fistulae and mucous membrane tuberculosis. The author used isoniazid in five cases of chronic ulcerative colitis. Dosage used was similar to that employed in tuberculosis, the indicated daily dosage being in the range of 3 to 5 mg. per kg. of body weight (150 to 300 mg. a day for the average adult).

The drug was first used in this series in a young man who was first observed September 28, 1953, with an anorectal fistula. He gave a history of chronic ulcerative colitis of four years' duration associated with diarrhea and repeated perianal abscesses and fistulae. Upon proctosigmoidoscopic examination, conditions typical of chronic ulcerative colitis were noted. Further investigation was negative for tuberculosis, regional ileitis and amebiasis. The patient was given isoniazid orally on a schedule of 300 mg. in three divided doses daily. When proctoscopic examination was carried out 11 days later, the rectal mucous membrane was practically normal in appearance, although it bled easily when touched with a cotton applicator. The patient felt better and had gained five pounds in weight. Diarrhea had ceased. The drug was continued in reduced dosage (Table 1) and the fistula was excised on November 23, 1953. Healing was complete and satisfactory on January 12, 1954. The drug was discontinued on March 8, 1954. When the patient was last examined, six months after the beginning of therapy, there was no relapse of chronic ulcerative colitis.

The drug then was given to four other patients (Table 1) with good results in each (Table 2). Particularly noteworthy are Cases 2 and 5. The patient in Case 2 had pronounced response in ten days, after having been in a relapse for five months, and for the

• Uniformly good response to isoniazid therapy was observed in five cases of chronic ulcerative colitis during an initial period of 3 to 6 months of treatment. In all cases the disease was in relapse at the time administration of the drug was started. There was both subjective and proctoscopic evidence of improvement. Isoniazid has little significant or serious toxicity.

first time in many months began to have normal stools. In Case 5 the patient had considerable improvement in three weeks; and when proctoscopic examination was carried out two months after the beginning of therapy, the mucous membrane of the rectum was practically normal in appearance and was in the best condition observed in six years.

Evaluation of the response to the drug was made primarily from proctoscopic findings. (In all cases, ulcerative colitis was confirmed by x-ray examination, but roentgen studies were not carried out after therapy.) All five patients said that they felt better. As soon as improvement was noted, proctoscopically and clinically, from ten to fourteen days after institution of therapy with 300 mg. in three divided doses daily, dosage was reduced to 150 mg. in 24 hours, in three divided doses.

TABLE 1.—Patients with chronic ulcerative colitis treated with isoniazid

Age and Sex	Duration of disease (years)	Duration of relapse (months)	Associated conditions
31 M	4	2	Fistula-in-ano
69 F	40	6	Coronary heart disease
33 F	2	3	None
40 M	1	2	None
46 F	6	6	None

TABLE 2.—Results of isoniazid therapy in chronic ulcerative colitis

Case	Time required for response to drug 300 mg per 24 hours (days)	Maintenance dose after response (mg. per 24 hours)	Duration of therapy to date (months)	Relapses
1	11	150	5	None
2	10	150	4	None
3	14	150	4	None
4	14	150	3	None
5	10	150	3	None

From the Department of Proctology, Mount Zion Hospital, San Francisco, California.

COMMENT

No attempt is being made at this time to explain the foregoing results. Inasmuch as isoniazid has little significant or serious toxicity,¹ this preliminary report is rendered so that the drug may be tried out in a larger series of cases of chronic ulcerative colitis and a proper evaluation made as to its place in the

treatment of a disease which is one of the great enigmas of medicine.

2211 Post Street.

REFERENCE

1. American Trudeau Society: Current status of isonicotinic acid hydrazide in the treatment of tuberculosis, Am. Rev. Tuberc., 65:649, March 1952.

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Postmenopausal Bleeding of Nonmalignant Origin

EDWARD J. BOMZE, M.D., Los Angeles

VAGINAL BLEEDING after completion of the menopause is usually viewed with alarm by patients and physicians. Even a relatively uninformed woman senses the ominous implications and seeks advice and reassurance. It is quite generally accepted and taught to both the medical profession and the lay public that vaginal bleeding coming on after the menopause must be considered as owing to malignant disease unless proven otherwise. Yet it is easier to demonstrate the presence of a malignant tumor if one exists in a given patient than it is to be certain there is no malignant lesion even though results of diagnostic procedures are all negative. Even when comprehensive examination elicits no evidence of carcinoma, the disturbing thought frequently remains that complete removal of the uterus and adnexa might disclose an early malignant tumor.

Since this situation, disturbing to both patients and physicians, is encountered frequently not only by gynecologists but by general surgeons and general practitioners, further inquiry into the benign causes of bleeding at this period of life would seem worth while. It would be very comforting to the patient if she could be told with confidence that there are a number of specific benign conditions which can cause bleeding after the menopause. With this purpose in mind, the author reviewed the records of 102 patients who were admitted to hospital because of postmenopausal bleeding and in whom no evidence of malignant disease was found after careful investigation. Some useful concepts were suggested by this study.

The patients were from 39 to 81 years of age. More than 60 per cent were between the fiftieth and sixtieth years. The interval that had passed between cessation of menses and the occurrence of bleeding ranged from four months to 30 years. There was no significant coincidence of onset of bleeding and length of time since cessation of menses.

The amount of bleeding varied. In some instances it was described as a pink or brown discharge or "spotting"; in others, as repeated or continuous vaginal bleeding, occasionally so profuse as to be called hemorrhage and to be associated with a low hemoglobin content in the blood when the patient entered the hospital. The duration of bleeding before the patient entered the hospital varied from one day to as long as four years (intermittently). It was noted that in all except two or three cases surgical measures for diagnosis and treatment were insti-

** A study was made of the medical records of 102 patients hospitalized because of postmenopausal bleeding. Diagnostic procedures used included vaginal examination, Papanicolaou smears, curettage and cervical biopsy.*

The major associated pathological conditions (possibly etiological factors) in the series were chronic cervicitis, fibromyoma of the uterus, endometrial polyps, cervical polyps and adenomyosis of the uterus. Sclerosis of the uterine vessels was suggested as another possible cause of this type of bleeding. Neither the amount and type of bleeding nor the pattern of associated symptoms were of diagnostic value.

A history of hormonal therapy prior to the onset of bleeding is not sufficient evidence to establish that as the cause of the bleeding and the patient should be as completely investigated as if this history were not present.

In over 61 per cent of cases in this series, uterine curettage with or without cervical biopsy, cauterization, conization or trachelorrhaphy, was the only treatment required for both diagnosis and therapy.

tuted promptly after the patient consulted a physician.

The amount and duration of bleeding was not of any particular diagnostic value but there was a suggested relationship between the amount of bleeding and the type of lesion. In general, bleeding caused by minor lesions of the vagina and cervix in this group of patients consisted mainly of bloody discharge or spotting. Bleeding of large amount was in the majority of cases associated with disease in the endometrium or uterus. However, these coincidences were not sufficiently constant to be considered diagnostic criteria.

In only 10 of the 102 records was there reference to hormone therapy and its relation to the bleeding under consideration. In seven cases it was said specifically in the history that the patient had been treated with estrogens or some hormone preparation before or concurrently with the bleeding. In three cases it was stated that the patient had not had hormone therapy. Although in the other 92 records no reference was made to the question of hormone therapy, it is more than probable that this factor was considered, for the patients were otherwise care-

fully studied. Data included in the office records of a patient are not always entered in the hospital charts, most of which are written by externs and interns. It was impractical to interview all the individual attending physicians. In any case, the information so obtained would have been of doubtful value since it would be hazardous to ascribe vaginal bleeding to hormone effect on the basis of the history alone, without further investigation as to other possible causes, for a patient who has had hormone therapy can also bleed from other causes.

Only about one-third of the patients had associated symptoms or complaints—feeling of pressure in the lower abdomen, lower abdominal cramps, mild backache, suprapubic discomfort, headache, soreness of the breasts, and a feeling of irritation in the vagina and vulva. These complaints appeared to bear no relation to the actual cause of the bleeding.

The diagnostic procedures used in this series of cases, in addition to pelvic examination, consisted of Papanicolaou smears, uterine curettage, biopsy of the cervix, and biopsy of the vagina.

The pathologist's reports in these cases showed a fairly large variety of lesions (Table 1). The most frequent pathologic diagnosis was chronic cervicitis, associated in some instances with ulceration or erosion of the cervical epithelium. Next most common were fibromyomata of the uterus (almost all of them submucous) and single and multiple fibroid tumors. Endometrial polyps were observed almost as often as fibroid tumors and in a fair number of instances were associated with them. The general impression at present seems to be that cervical polyps are the most frequent cause of bleeding from nonmalignant lesions after the menopause. However, this diagnosis was recorded in only 20 per cent of the cases in this series.

Adenomyosis was the diagnosis in approximately 10 per cent of these patients. In a number of instances it was associated with fibroid tumors; in the remainder it was either the only causative factor or was accompanied by minor lesions. This is surprising for two reasons. First, adenomyosis is not generally thought of as a cause of uterine bleeding; second, adenomyosis and endometriosis are believed to undergo involution at the time of the menopause. The mechanism by which adenomyosis can produce uterine bleeding is not clear and should certainly be studied further.

In 12 cases the diagnosis was endometrial hyperplasia. Eight of the women with this diagnosis had completed the menopause eight months to four years previously, and four had not menstruated for 17 to 30 years. None of these women had a history of hormone therapy, but it is difficult, on the basis of accepted theories of the menopause, to account for hyperplasia in the absence of female sex hormones from some source. Material curetted from one 44-

TABLE 1.—Pathologic diagnoses in 102 cases of postmenopausal vaginal bleeding not caused by malignant disease

Diagnosis	No.	Remarks
Chronic cervicitis.....	38	4 with ulceration
Fibromyoma of uterus.....	23	
Endometrial polyps	21	
Cervical polyps	19	
Endometrial hyperplasia.....	12	
Adenomyosis uteri.....	10	
Fibrosis of uterus.....	10	
Erosion of cervix.....	7	
Cystic glandular hyperplasia of cervix....	5	
Squamous metaplasia of cervix, mild.....	2	
Squamous metaplasia of endometrium.....	1	
Chronic vaginal ulcer.....	1	Non-specific
Fibro-epithelial papilloma of vagina.....	1	
Theca cell tumor of ovary.....	1	Benign histologically
"Foci of necrosis in endometrium with deciduoid reaction in stroma".....	1	
Hyperkeratosis of cervix.....	5	
No definite pathologic diagnosis.....	12	

year-old patient who was two years past the menopause was reported as showing "foci of necrosis suggesting a postparturient reaction, with a deciduoid reaction in the stroma"—a diagnosis which could be explained similarly on the basis of hormonal effect.

There were two instances of mild squamous cell metaplasia of the cervix and one of "squamous cell metaplasia of the endometrium." It may be that the lesions in these three cases are early carcinoma *in situ*, but the question has not been resolved as yet, for the patients all had curettement within the past year and a half and none has had any further bleeding.

In many of the cases in which the uterus was removed, sclerosis of the uterine vessels was noted in the pathologist's report. The observation was made often enough in this series to suggest the possibility that sclerosis may in some way have been an etiologic factor in the bleeding that occurred from senile atrophic uteri, many of which, on preliminary curettement, did not yield sufficient endometrial tissue for microscopic study.

In 23 cases, treatment consisted of simple dilatation and curettage; in 41, curettement was combined with biopsy of the cervix; and in five, biopsy of the cervix was done with or without cauterization, conization, or trachelorrhaphy. One patient had cervical amputation; 39 had hysterectomy, done vaginally or abdominally, with bilateral salpingo-oophorectomy also in most cases.

Follow-up information was obtained on about 50 per cent of the patients. The remainder were either too recently treated for evaluation or were no longer in communication with the physicians who attended them. Only one patient is known to have had recurrence of bleeding. She was a 55-year-old virginal

woman who, three years after menstruation stopped, began to bleed vaginally every two weeks, at times profusely. After eight months she consulted a physician who found nothing of significance on examination, but nevertheless did a diagnostic curettage. The material obtained was scanty and it was reported as showing "an occasional glandular struc-

ture with no evidence of malignancy." The patient was well for six months afterward and then bleeding began again. Total hysterectomy was done and an early endometrial carcinoma was discovered. Three years later she was free of disease and was being examined at regular intervals.

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Thyroid Carcinoma

An Approach to Management of the Disease

G. L. SCHOLNICK, M.D., G. ARNOLD STEVENS, M.D., and
J. M. BEAL, M.D., Los Angeles

INTEREST IN THE MANAGEMENT of carcinoma of the thyroid gland has increased recently because attention has been focused on two factors related to this disease. First, the high incidence of carcinoma in solitary thyroid nodules has led to excision of many such lesions. It seems likely that this approach will lead to the detection of a larger number of neoplasms in the early phases of development. Second, radioactive iodine (I^{131}) has become available and is used frequently in the diagnosis and treatment of thyroid diseases including neoplasms. The usefulness of radioactive iodine in the therapy of thyroid carcinoma is still being evaluated.

This report is based on observations of 34 patients with carcinoma of the thyroid gland who were observed between 1940 and 1953 on the surgical service at the Veterans Administration Center, Los Angeles.

RESULTS OF STUDY

Incidence: Most of the patients in a Veterans Administration hospital are men, and 30 of the patients in this series (85 per cent) were men. The youngest was 19 and the oldest 71 years of age and the average age was 43 years.

Symptoms (Table 1): Enlargement of the thyroid gland without other symptoms, was the most common symptom; it occurred in 13 patients. The presence of the goiter was previously unknown to three of these patients and was detected during a routine physical examination. In six patients a mass at the side of the neck representing lymph node metastasis was the presenting symptom. Four patients, who had had goiter for years, sought medical attention because of recent weight loss. Four had noticed recent rapid increase in size of a thyroid nodule which had been present for years. Two had painful, enlarging thyroid glands. Dysphasia and dysphonia, due to an enlarged goiter, were the presenting complaints in only one patient. In one instance a routine x-ray film of the chest revealed a metastatic lesion in the lung, which led to the discovery of the primary thy-

roid carcinoma. In one patient a small focus of unsuspected carcinoma was observed during thyroidectomy for a toxic nodular goiter. The two remaining patients had previously had operation elsewhere and the original symptoms were not recorded.

The age at which thyroid or cervical node enlargement first appeared varied from 9 to 71 years, with an average age of 38 years. In one third of the cases such an enlargement was noted before the thirtieth year. In 30 per cent of patients goiter had been present more than six years, and one patient had had goiter for 25 years before thyroidectomy was performed.

Signs: All 34 patients had nodular goiters. The size of thyroid enlargement at the time of examina-

Presented before the Section on General Surgery at the 83rd Annual Session of the California Medical Association, Los Angeles, May 9-13, 1954.

From the Veterans Administration Center, Los Angeles, California, and the Department of Surgery, University of California Medical School, Los Angeles.

TABLE 1.—Symptoms first noted in 34 patients with thyroid carcinoma

Asymptomatic goiter.....	13
Lateral cervical metastasis.....	6
Goiter plus recent weight loss.....	4
Recent growth in thyroid nodule.....	4
Painful, enlarging goiter.....	2
Dysphagia and dyspnea.....	1
Lung metastasis.....	1
Toxic nodular goiter.....	1
Unknown.....	2
	34

tion could be accurately ascertained from the records in only 16 of the patients, all of whom had clinically solitary thyroid nodules. These nodules varied from 5 mm. to 5 cm. in diameter with an average of 2 cm. Only five thyroid nodules in this series were recorded as being unusually hard. Only one patient had symptoms of hyperthyroidism.

Use of radioactive iodine: After I^{131} became available at this hospital in 1949, each patient was given a diagnostic tracer dose of 1 to 2 microcuries of I^{131} to determine the functional activity of the thyroid gland.¹ Following this test, doses of between 200 and 300 microcuries of I^{131} were given in order to obtain a scintigram of the neck.¹⁰ The amount administered depended on the maximum uptake of the tracer dose by the thyroid gland. In five of the six patients with thyroid carcinoma studied preoperatively in such a manner, an area of decreased function was demonstrated at the site of the carcinoma (Figure 1).

Four to six weeks following thyroidectomy, radioactive iodine was again administered to determine if functioning thyroid tissue remained in the neck. Preliminary observations, which will be published later,² revealed that metastatic lesions, if present, were demonstrated by means of I^{131} much more consistently when total thyroidectomy had been performed than after partial thyroidectomy. If metastatic lesions were not demonstrable by the techniques described above, they sometimes could be detected by administering thyrotropic hormone intramuscularly before the dose of I^{131} . The use of propylthiouracil for one month to increase the I^{131} uptake in cases in which metastasis was suspected, according to the technique of Rall,¹² was unsuccessful in two patients.

Pathology: The predominant histologic type encountered in this series was papillary adenocarcinoma, and it occurred in 14 patients. Solid carcinoma was found in seven patients, and a mixed carcinoma in seven others. Four cases were classified as follicular adenocarcinoma and one as Hurthle cell carcinoma. One patient had a giant cell carcinoma.

Ten patients with cervical lymph node metastasis underwent radical neck dissection. The histologic types in this group were papillary adenocarcinoma in

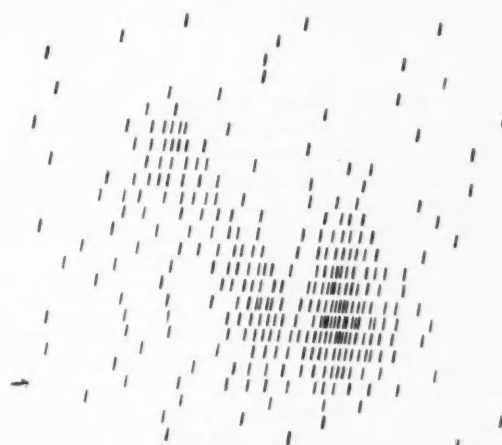


Figure 1.—Thyroid scintigram showing an area of decreased I^{131} uptake in a solitary nodule of the right thyroid lobe.

TABLE 2.—Follow-up on 34 patients with thyroid carcinoma

Status of patient	Number
<i>Living 24:</i>	
Alive 5 years or more.....	5
Follow-up less than 5 years.....	19
<i>Dead 10:</i>	
Died within 4 years.....	8
Died after 25 years.....	2

5, follicular adenocarcinoma in two, solid carcinoma in two, and mixed carcinoma in one.

Follow-up: (Table 2) In this series 24 patients are alive and ten dead. In the living group, five have survived five years or more; the follow-up studies on the remaining 19 have been in progress less than five years. In the latter group, eight (23 per cent of the 34 cases) died within four years following diagnosis. Seven of these eight are known to have died of thyroid cancer; the cause of death in the other one is uncertain; however, he had far advanced metastatic carcinoma when last observed. The other two patients in the latter group lived 26 and 29 years postoperatively and died of other causes. One of these two had persistent metastatic thyroid carcinoma at the time of his death.

Evaluating the effectiveness of therapy for thyroid cancer is difficult because the natural course of the disease varies so greatly.⁹ Occasionally patients survive many years without treatment, and hence assessment of the merits of various therapeutic methods is hazardous unless a long follow-up study is available. This is illustrated by the two patients who survived 26 and 29 years after institution of treatment. One was known to harbor metastatic lesions for several years, and yet he died of unrelated diseases.

Although the period of follow-up in many of the patients in this series was short, it was interesting

to compare the duration of survival of various patients with the type of treatment administered.

Relation to Early Treatment: Treatment was instituted within six months of onset of symptoms in 14 patients. There are twelve survivors in this group, but only two of them have been followed for five years. One patient died six weeks after biopsy of an obviously malignant goiter; another died 18 months after partial thyroidectomy and x-ray treatment for highly malignant mixed cell carcinoma.

Eleven patients received treatment between six months and five years of onset of symptoms. Eight of them are alive, but none of the cases have been followed beyond three years. The other three patients died within three years.

Six patients had symptoms longer than five years before receiving treatment. Five are alive, and three of them have survived beyond five years. One died of malignant disease.

In four patients the duration of symptoms before treatment could not be definitely established.

Relation to Type of Surgical Treatment: (Table 3) Four patients with far advanced thyroid carcinoma received no surgical treatment and died within three years. The diagnosis was established antemortem by biopsy.

Partial thyroidectomy was done in 13 patients. Ten of this group are alive, and of five followed five years or longer none had recurrence. The other three patients died within five years from recurrent carcinoma, solid in one case, giant cell in one, and follicular adenocarcinoma in the third.

Total thyroidectomy was done in seven patients. Although all are alive, only one has been observed for a period of five years since operation. In that case there has been no recurrence. Two patients with solid carcinoma developed metastases—to cervical and axillary nodes in one case and generalized in the other.

Thyroid lobectomy and radical neck dissection was performed on five patients. Four are alive without recurrence, but in only one case is the follow-up period more than five years. One patient died four years postoperatively of a metastatic solid carcinoma.

Five patients underwent total thyroidectomy and radical neck dissection. All are alive, but only one has been observed for as long as five years, and in that case a recurrence is now present in the neck.

The relatively small series reported in this paper reaffirms the observation that the great majority of cases of carcinoma of the thyroid occur in non-toxic nodular goiter. It has also been noted that the incidence of carcinoma is higher in patients who have nodules that are clinically solitary.^{3, 4, 6, 7, 11, 13} Because the morbidity and mortality of thyroidectomy is significantly lower than the possibility of

TABLE 3.—Relation of treatment to prognosis

Operation	No. cases	Alive		Died of carcinoma within 5 years
		5 year survivors	Follow-up less than 5 years	
None	4	0	0	4
Partial thyroidectomy	13	5	5	3
Total thyroidectomy	7	1	6	0
Lobectomy plus radical neck dissection	5	1	3	1
Total thyroidectomy plus radical neck dissection	5	1	4	0

TABLE 4.—Management of non-toxic nodular goiter and thyroid carcinoma

- I. Preoperative work-up
 1. Routine plus I^{131} uptake study
 2. Thyroid scintigram
- II. Surgical treatment
 1. Lobectomy—solitary nodule
 2. Total thyroidectomy
 - a. Large lesions
 - b. Papillary adenocarcinoma
 3. Radical neck dissection
 - a. Cervical nodes
 - b. Papillary adenocarcinoma
- III. Postoperative I^{131} studies
 1. Scintigram of neck
 2. Survey of entire body
- IV. Treatment of metastatic lesions
 1. Excision of accessible metastases
 2. I^{131} if lesion concentrates isotope
 3. Roentgen therapy
- V. Prolonged follow-up

nodular goiters harboring carcinoma (5 per cent as against 24 per cent) surgical intervention should be undertaken after detection of a nodular goiter. It seems logical that removal of such lesions should offer the patient a better chance of survival than would delaying until more obvious evidence of carcinoma had developed. The authors' concept of the most reasonable program of management for non-toxic nodular goiter and for thyroid carcinoma (see Table 4) is as follows:

A preoperative evaluation of the patient should include a radioactive iodine uptake study to determine functional activity of the thyroid gland. Then a thyroid scintigram should be made to outline any areas of increased or decreased concentration of the isotope. The presence of an area of decreased uptake in a thyroid nodule is suspicious of carcinoma; while an area of increased uptake offers considerable assurance against the presence of carcinoma in that area.

Lobectomy has been proposed as a reasonable approach to the initial management of solitary thyroid nodules.⁴ This has not been more technically difficult in the authors' experience than subtotal removal of the lobe. More important, lobectomy avoids the inadvertent transection of unrecognized neoplastic tissue, and in some instances this method provides adequate therapy for a small localized lesion of thyroid carcinoma.

Often it has been found that frozen sections do not reveal the exact histologic type, and on occasion do not establish definitely the presence or absence of neoplasm. In such instances precise diagnosis must wait for preparation of permanent sections.

If the pathological report shows benign thyroid tissue, hospitalization is terminated after recuperation from the operation. If the thyroid tissue is malignant, then further treatment must be considered.

Total thyroidectomy is indicated in cases of large malignant lesions or lesions involving the isthmus. In the majority of cases total thyroidectomy would appear to offer the greatest protection against local recurrence. The need for this is illustrated by the demonstration of multicentric foci or satellite tumor nodules within both lobes of the thyroid gland in some patients who have papillary adenocarcinoma. While it is entirely possible that such additional foci represent independent neoplastic sites, it appears more likely that they represent spread within the intraglandular lymphatic channels with which the thyroid is known to be richly supplied. Such a premise strongly recommends total thyroidectomy.

Total thyroidectomy also offers certain advantages in the employment of I^{131} . The total removal of functioning thyroid tissue enhances the affinity of metastatic thyroid carcinoma for the isotope so that I^{131} can be useful in the detection and treatment of such a lesion.

The indications for radical neck dissection for thyroid carcinoma are still somewhat uncertain. The authors believe that radical neck dissection is indicated in all types of thyroid carcinoma when cervical lymph node metastasis is detected and when metastasis is limited to the neck. Cervical lymph node metastasis is frequent in papillary carcinoma of the thyroid, and radical neck dissection therefore appears indicated when the primary thyroid neoplasm is of this type.⁵ Neck dissection should include resection of the sternocleidomastoid muscle and internal jugular vein. Ten of the patients in the present series had radical neck dissection; in five cases the thyroid lesion was papillary adenocarcinoma.

Postoperatively, radioactive iodine studies are obtained in four to six weeks. One of the most important uses of I^{131} in relation to carcinoma of the thyroid is the diagnostic detection of persistence of thyroid tissue following thyroidectomy. This can be accomplished by administering tracer amounts of I^{131} , sometimes preceded by thyrotropic hormone, and then obtaining a scintigram of the neck or suspected anatomical site. In three of six patients who had undergone total thyroidectomy residual thyroid tissue in the neck was demonstrated by means of such a test. When functioning thyroid tissue is not present in the neck, a survey of the entire body may be made. Such a survey is repeated at inter-

vals until metastatic lesions are detected or until the patient requires oral supportive thyroid treatment.

If solitary metastatic lesions are detected and are surgically accessible, they should be excised. The use of therapeutic doses of radioactive iodine in the treatment of thyroid carcinoma has been discouragingly limited because the malignant tissue usually does not concentrate I^{131} sufficiently to provide the degree of radiation required for lysis of the tumor. However it has been the authors' impression that radioactive iodine has provided palliation for some patients who had lesions that were not accessible to surgical removal. An evaluation of the use of I^{131} in this regard is in progress.² When lesions did concentrate the isotope, it appeared to be more effective than roentgen therapy; and it should be remembered that the use of radioactive iodine does not preclude the use of external irradiation.

Long-term follow-up studies will be necessary to evaluate any program of therapy because of the protracted course of many cases of thyroid carcinoma. Many years will elapse before a definitive appraisal can be made of the therapeutic methods now advocated.

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Acne Conglobata

Use of Cortisone and Corticotropin in Therapy

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ACNE CONGLOBATA is a disease characterized by the presence of cystic abscesses, confluent follicular and perifollicular inflammations and intercommunicating cysts. These lesions affect primarily the face, neck, chest and shoulders and are the cause of serious and disfiguring scars. Patients with this disease are usually from 15 to 25 years of age and have an antecedent history in most cases of acne vulgaris of varying degrees of severity.

Acne conglobata may have a fulminating onset and course. Conventional therapy, consisting of antibiotics, local measures and roentgen irradiation, is frequently disappointing. Because of the explosive nature of the lesions and the seemingly disproportionate scarcity of bacterial infection in them, the possibility of underlying Arthus or Schwartzman reaction was considered. On this presumption, the authors administered cortisone and corticotropin to six patients with acne conglobata.

The patients ranged in age from 13 to 18 years. Four were male and two female. A cardiolipin blood test for syphilis was done in all cases and in all the results were negative. The total number of leukocytes in the blood was within normal limits in all cases, as were the differential leukocyte count, hemoglobin content, sedimentation rate, urinary 17-ketosteroid determinations, basal metabolic rate, serum cholesterol and results of urinalysis. No abnormalities were noted in x-ray films of the chest. In five cases staphylococci grew on cultures of purulent exudate from the cysts, and in one the culture was sterile. Antibiotics were employed and the agent used in each case was the one to which the organism was found to be most sensitive as determined by sensitivity studies.

CASE 1. An 18-year-old male who had had acne vulgaris for four years, had explosive onset of acne conglobata in July 1953. Papules, pustules and intercommunicating cysts 1 to 2 cm. in diameter involved the chest, face and upper back. Previous intensive therapy had been relatively unsuccessful.

Treatment consisted of daily intravenous infusions of 40 units of corticotropin (ACTH) in 500 cc. of

• Six patients with acne conglobata were treated with cortisone and adrenocorticotrophic hormone. Definite immediate improvement was observed in all of them. In three cases control of the disease was maintained on relatively low doses of steroid. In one case there was response to superficial x-ray therapy after the acute phase of the disease had subsided in response to steroids. Resistance to steroid therapy apparently developed in one patient after approximately 18 months of treatment. One patient responded to treatment and then remained well (for two months when last observed) although steroids and all other treatment were discontinued.

The combined use of antibiotics and steroids in the patients treated gave the best results.

5 per cent dextrose in distilled water. Definite improvement was noted within two days. The patient was discharged from the hospital one week after admission, greatly improved. Relapse occurred after dismissal from the hospital. At the time of report, therapy consisted of 40 units of corticotropin gel given intramuscularly two times a week, supplemented with achromycin by mouth. The lesions again were reduced in size and the general appearance of the patient was improved.

CASE 2. A 16-year-old girl who for three years had had acne vulgaris, had explosive onset of acne conglobata. There were many papules, cysts, pustules and keloid-like lesions on the face, back and chest. Therapy carried on over a four-month period was unsuccessful. Prompt response was noted within 72 hours after three daily intravenous infusions of 20 units of corticotropin in 500 cc. of 5 per cent dextrose in distilled water. The patient was also given 2 gm. of terramycin daily.

She was discharged from the hospital after five days, considerably improved. A mild exacerbation occurred two days after leaving the hospital.

CASE 3. A 13-year-old girl had acne vulgaris for six months prior to an explosive onset of acne conglobata involving the face, chest and shoulders. Previous therapy had been relatively unsuccessful. Administration of 75 mg. of cortisone and 1 gm. of aureomycin by mouth daily was begun. Improve-

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Figure 1.—*Left*, cystic and keloid lesions of the face (Case 6) before steroid therapy. *Right*, after steroids were added to treatment for a period of two weeks.



Figure 2.—*Left*, crusting and hypertrophic scars on back (Case 6) before addition of steroids to therapy. *Right*, after two weeks of steroid therapy.

ment was noted after five days and was maintained for six weeks. On discontinuance of the therapy there was mild exacerbation of the lesions.

CASE 4. A boy 18 years of age had acne vulgaris for six years, when an explosive onset of acne conglobata occurred. All previous therapy had been unsuccessful. Many pustules, pitted scars, keloids and cysts were noted on the upper back, chest and face.

Treatment consisting of 150 mg. of cortisone given daily for six days by mouth resulted in definite improvement, in that the cysts decreased in size and no new ones appeared.

CASE 5. A 14-year-old boy who was examined in the Stanford University outpatient clinic in July

1952, had had acne vulgaris for one year. In March of 1952 acne conglobata developed explosively over the face, chest and upper back. Numerous pustules, cysts and intercommunicating keloid-like lesions practically covered the face. Previous therapy, including superficial x-ray treatment, had been unsuccessful. The patient was hospitalized and given 200 mg. of cortisone daily and 500 mg. of erythromycin four times daily. There was response to therapy within 48 hours, manifested by flattening of the cysts and a decrease in the number of pustules and keloids.

The patient continued to improve for the next four months while doses of cortisone and terramycin were gradually reduced. Additional x-ray therapy

was administered with heavier filtration and the disease remained under control for the next ten months. An exacerbation occurred in December 1953 and the patient was hospitalized and given 40 units of corticotropin in 500 cc. of 5 per cent dextrose in distilled water intravenously over an eight-hour period. Improvement was slight but definite and the patient was discharged from the hospital after one week. Administration of cortisone, 75 mg. daily; and erythromycin, 600 mg. daily, was continued. New lesions developed after discharge from the hospital and apparently resistance to the therapeutic effects of the steroid had developed.

CASE 6. A 15-year-old boy had acne vulgaris for six months before an explosive onset of acne conglobata occurred. There were many hypertrophic crusted lesions, depressed scars, keloids and fluctuant cysts on the back, central portion of the chest, face and scalp. Corticotropin gel (30 units) and terramycin were administered in addition to local therapy in the form of hot compresses. The patient was discharged from the hospital, considerably improved, after ten days of this therapy. The medication was gradually withdrawn and, when observed two months later, the patient had been asymptomatic without treatment of any kind.

DISCUSSION

There were certain common factors in the six cases here reported. The patients were between the ages of 13 and 18 and all had acne vulgaris before the development of acne conglobata. All had improvement within two to six days after steroid therapy was begun. The rate of response appeared to be influenced by the route of administration of the drug—earlier when given intravenously than intramuscularly or orally. The route of administration was determined by the severity of the disease process. It was further significant that staphylococci were cultured from exudate in five of the six cases.

Although the influence of adrenal cortical hormones upon hypersensitivity is still in the early stage of evaluation, it seems inevitable that studies of these agents will reveal basic fundamental information concerning the immunological and hypersensitivity states observed in clinical medicine.⁵

The mechanisms involved in the use of cortisone and adrenocorticotrophic hormone in hypersensitivity reactions are poorly understood. In rabbits antigen-antibody union is blocked if steroids are given in massive dosage. There does not appear to be a human counterpart, for the small dosage which is

clinically effective in man does not consistently inhibit or suppress antibody formation. Furthermore, if preformed antibody is given, it disappears too slowly to explain the dramatic clinical improvement observed early in patients who receive steroid therapy.³ Conversely, antibodies produced by previous vaccination have been shown to decrease by as much as 25 per cent under the influence of cortisone.¹ This would suggest that there is a suppression of antibody formation.

"It is not completely clear why the passive Arthus phenomenon is unaffected, whereas in the Schwartzman phenomenon, a histologically similar reaction, the effects of the preparatory dose of toxin induces an unusually severe reaction whereas the second, or challenge dose of toxin, is inhibited."³ Neither has blood vessel damage, which is believed to be a constant change in hypersensitivity reactions, such as the Arthus and Schwartzman phenomena, been exhibited in biopsy specimens from any of the cases observed by the authors.

When administered in therapeutic doses cortisone suppresses adrenal cortex activity by inhibiting pituitary adrenocorticotrophic output.⁶ The urinary 17-ketosteroid determinations usually reflect a decrease in androgen secretion,⁴ especially in females. In the six patients in the present study the values for urinary excretion of 17-ketosteroids were normal before and during steroid therapy.

Although it is impossible in the light of known experimental data to explain the improvement noted in the cases here reported upon, it was probably owing to the steroids, especially when the dramatic response to treatment and the exacerbations upon discontinuance of such therapy is considered.

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Proctologic Disorders in Sex Deviates

A Study of Sixty-eight Cases of Sodomy

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ALTHOUGH SODOMY (anal intercourse) has been referred to for centuries in historical and biographical writings, the medical literature on this subject is relatively scanty. A number of case reports on transvestism,^{9, 10, 17} rectal venereal disease^{7, 12, 18} and the medicolegal aspects of sodomy^{8, 11, 14} have appeared within the past 25 years, mainly in European and South American journals. In the United States, recent literature on the subject is predominantly psychiatric and sociologic.^{1, 4, 6, 20} No study of the total proctologic problem resulting from the practice of sodomy was discovered.

It is the purpose of this paper to report on a study of 68 persons who practiced passive sodomy—their histories, methods of practice, and proctologic disorders—and to emphasize the special problems for physicians in examining and treating such patients.

MATERIAL AND METHODS

Fifty inmates of two penal institutions of the California State Department of Corrections and 18 patients observed in private practice provided the clinical material for this study.

Group I—Inmates

This group was made up of 50 homosexual inmate volunteers at two California state prisons who admitted to having practiced passive sodomy before imprisonment. Forty-two of the group were white and eight were Negro. The age range was from 20 to 38 years, with a mean of 27 years. All in the group were assured that the information they gave would remain confidential and that no findings that might serve as a means of identification would be used. They were studied by personal interview and proctologic examination.

*Interview.** The questions asked about the individual experiences with sodomy dealt with age at the time of initial practice, average frequency, the immediate effects on the anus and rectum, and the techniques employed. In addition to providing information on the practice of sodomy, the answers were to be correlated with proctologic findings. Individual opinion as to the quality and accessibility of medical care before imprisonment was solicited. Estimates as to the prevalence of sodomy in the

*All questions concerned period before imprisonment.

• Sixty-eight patients, 50 of them in penal institutions, who practiced passive sodomy were studied by interview and examination with regard to type of homosexuality, appearance, age at onset, frequency of practice, techniques, and proctologic findings.

A high incidence of anal cryptitis was observed. A sign observable on digital examination, possibly peculiarly indicative of the practice of sodomy, was noted in many cases. Particular care is needed in the examination and treatment of anorectal diseases in sodomists and certain precautions must be taken as to hospital accommodations.

general public were obtained. From the answers to the foregoing questions, and from subjective impressions, an arbitrary division as to the type of homosexual in the group was made as follows:

Type A—Normally masculine in appearance and manner, with occasional homosexual contact.

Type B—The so-called bisexual, who usually but not always assumed the active role in sodomy and was confused as to his homosexuality.

Type C—Sexual relationships exclusively homosexual; admitted being homosexual, and more or less adjusted to it.

Type D—Homosexual who tried to dress and live as a female.

Proctologic Examination. Each patient was given a proctologic examination which included proctologic history and a physical examination consisting of external inspection and digital and anoproctoscopic examination. Smears and photographs were taken when indicated.

Group II—Private Patients

This group consisted of 18 patients observed in private practice—16 males and two females—who were presumed to have practiced passive sodomy. Although the interviewing technique used with Group I was not suitable for this group, the same classification as to type of homosexuality and effeminacy of appearance was employed. The group was studied by proctologic examination, and the problems of treatment were reviewed.

Proctologic examination. This included a proctologic history, listing of chief complaints, inspection, digital and anoproctoscopic examination, and laboratory tests when indicated.

RESULTS

Group I.

Interview. The distribution of homosexual types was: Type A, 19; Type B, 7; Type C, 17; and Type D, 7. The age at which sodomy was first practiced ranged from 6 to 22 years, with a mean of 14.5 years. Frequency varied from a rare experience to ten times a week, one patient admitting to a continuous frequency of two times a week for 17 years. Six patients said that they were forced into the initial experience, which they recalled as having been extremely painful. All patients reported having tried various methods of homosexual outlet. Ten said that they practiced sodomy only. Twelve preferred sodomy but practiced other methods as well. Fifteen practiced sodomy occasionally, usually for the purpose of pleasing the active partner, and 13 practiced it rarely finding it painful or unpleasant. Six patients admitted having assumed both the active and passive roles, but each of them had a preference for one or the other role. Sixteen expressed a preference for a "normal" male as a sexual partner; the remaining 34 established and maintained sexual relationships only with other homosexuals. Twenty-two of the group reported either a lack of pleasure or actual discomfort in the practice of sodomy. Seven experienced a slight pleasurable sensation, seven attained occasional orgasm, and 14 had orgasm frequently. Of the latter, half used additional friction to the genitalia to attain sexual outlet.

Rectal masturbation was admitted by three. The remaining 47 found the anus erogenous only when in contact with another male. Those who masturbated described the use of sausages, brush handles and rolled-up magazines, to name a few of the many items mentioned. Massage of the "gland" was depicted as the goal. One patient complained of getting an erection during defecation, especially when the stool was hard; when the evacuation was large, defecation would be accompanied by a seminal emission. Only two patients admitted to coprophiliac tendencies; the remainder expressed disgust with the presence of fecal material on the skin, and with fecal odors.

The estimates of this group as to the prevalence of sodomy in the general public varied from 2.5 per cent to 20 per cent who practiced it frequently and 10 to 60 per cent who practiced it occasionally. It was estimated that 40 to 50 per cent of all male homosexuals practice sodomy exclusively or frequently; that almost all homosexuals have tried passive sodomy at one time or another; that the

practice of sodomy was more prevalent in large cities and uncommon in small towns, and that it was more prevalent on both coasts of the United States than in the Middle West. Several of the college graduates in the group claimed that sodomy was preferred to other methods by the more sophisticated homosexual.

The majority of the members of this group had never consulted a physician before imprisonment. Many expressed fear of unsympathetic treatment and revulsion on the part of the physician. Many attempted to appear heterosexual in their daily contacts and were afraid that a consultation with a physician would lead to exposure. A number accused physicians of lecturing about "going straight." They found this particularly objectionable.

From the 50 interviews a pattern of performance emerged. Generally speaking, the performance of sodomy was described as follows: The passive partner usually washes out the rectum by means of an enema or, if this is unavailable, attempts to empty the rectum. He may prefer to lie on his back, side or abdomen. A lubricant, usually petroleum jelly, is applied to his anus and to the penis of the active partner. Penetration is often associated with slight pain, which is aggravated by hasty insertion or disproportion in the sizes of the two organs. After ejaculation is attained by the active partner and the penis is withdrawn, the passive partner again empties the rectum.

Many of the patients said they experienced pain, bleeding and a sensation of looseness and gas-incontinence for a period of one-half hour to several days following sodomy. Three patients described such a syndrome as an "upset," which they apparently related to menstruation in the female, and during which sanitary napkins were worn and intercourse temporarily avoided.

Proctologic Examination.

History. While almost every member of the group stated that sodomy acted as a temporary laxative, only nine had any disturbance in bowel habit: six complained of constipation, two of irregular evacuation, and diarrhea occurred in one patient who had a rectal stricture caused by lymphopatia venereum. Those who practiced sodomy frequently stated that there was a definite increase in the total number of daily bowel movements during periods of increased sexual activity. Six patients gave a history of previous rectal operation, hemorrhoidectomy in five cases and fissurectomy in one. One was 15 years of age at the time of operation, one 17, two 18, one 20 and two 25. One patient received injections for hemorrhoids, and one was given a prescription for suppositories.

Twenty-two men had definite complaints referable to the rectum. These included, "piles," 9; painful

evacuation, 4; wetness, 3; itching, 2; incontinence as to gas, 2; bleeding, 2; tightness, 1.

Inspection. Skin tags were noted in six cases, condylomata acuminata in four, visible, prolapsing hemorrhoids in three, external thrombus in one, visible skin erosion in one and fungating neoplasm in one. It was not possible to relate the appearance of the anus to the practice of sodomy; there was no appreciable difference in the appearance of the anus in those who practiced sodomy frequently and those who practiced it rarely. One possible exception was a transvestite who trained the growth of the perianal hair. One patient who had anal skin tags felt that they resembled labia, but they were small, ordinary anal skin tags.

Digital. The digital examination revealed an interesting, possibly diagnostic sign. It appeared in 30 cases and it seemed that there was some relationship between the extent of indulgence in sodomy and the degree of this sign. As the examining finger entered the anal canal, there was a sudden, brief contraction of the sphincters, causing resistance to penetration at the intermuscular septum. This was immediately followed by pronounced relaxation of the musculature of the anal canal, which then appeared widened. The examination resembled the digital examination that is done after saddle anesthesia and before beginning anorectal operation. When the sign is present, the anoscope can be passed with no resistance. If the sign is indeed due to the mechanics of sodomy, it would probably be encountered in rectal masturbators as well. Two patients could voluntarily relax the anal canal musculature.

More extensive digital examination was difficult, especially when contact with the prostate was made, for this brought embarrassing and unpleasant reactions in the patient, especially those of the more effeminate type.

Anoproctoscopic examination. Anoscopic and proctoscopic examination were accomplished with some difficulty because of the physical and psychological responses induced by the passing of the instruments. Internal hemorrhoids were found in 17 cases—small in three cases, moderate in nine, large in two, and prolapsing in three. There were four cases of hypertrophic anal papillae, two of blind fistulae and two of anal ulcer. The most remarkable finding was the high incidence and degree of cryptitis. Definite cryptitis was present in 26 cases and in eight cases it was pronounced or severe. The crypts involved were generally deep and unusually wide, and the color of the overlying tissue was darker than normal. Smears of exudate taken from the lesions in the severe cases were negative for gonococci.

One patient had a typical lymphopathia stricture. Result of a Frei test for lymphogranuloma was positive. Since he was a homosexual of Type D, prefer-

ring sodomy, his sexual activity was limited. Nevertheless, in 1950, when first observed, he refused treatment, hinting that he was attempting to dilate the stricture. He died in 1952 of a fungating squamous carcinoma of the anus, which was inoperable when he finally sought treatment.

The proctologic findings in Group I were brought to the attention of the medical authorities only when the specific inmate so requested. The medical facilities in the state penal institutions are excellent, the equipment modern, the staffs well trained, and any inmate having rectal complaints can get treatment if he wishes.

Group II (16 Men, 2 Women)

The males were for the most part only slightly effeminate in appearance, and several seemed quite masculine. The average age was 29.7 years, as compared with an average age of 39.3 for 100 unselected patients with proctologic disease in the same practice. History-taking, while successful in eliciting proctologic complaints, was difficult when applied to homosexuality. Once they had overcome an initial suspicion, some patients were willing to discuss their sexual problems; others would admit only to being homosexual and would answer no more questions. Several ascribed occasional homosexual lapses to alcohol.

Proctologic history. The complaints were usual for the findings. An unusual number of complaints referred to condylomata acuminata.

Inspection. The following pathologic conditions were noted: condylomata acuminata on the perianal skin, seven cases; visible protruding hemorrhoids, three cases; secondary opening of a fistula, two cases; anal ulcer, two; erosion of the skin, two; abscess, one; sentinel tag, one; oxyuriasis, one.

Digital examination. The digital sign previously mentioned was present to some degree in most of the males.

Anoproctoscopic examination. The following conditions were noted: Internal condylomata acuminata, 3 cases; hemorrhoids, 5; anal fissure, 2; fistula, 4; oxyuria infestation, 2. Nine patients had cryptitis similar in type and severity to that seen in patients in Group I. One of the women in the group had severe purulent proctitis, presumably related to a positive smear for gonococci, and the other had a traumatic ulcer in the anal canal that resembled a fissure but was not related to a crypt infection.

Laboratory. Gram-negative intracellular diplococci were noted on smears in four cases. In two cases these organisms were associated with condylomata acuminata, in one with hemorrhoids and cryptitis, and in one (previously described) with the proctitis. Except for the latter case, there was no clinical evidence of gonorrhea in the anorectum. In one

case in which the smear was positive, the last contact had taken place four weeks before the examination. In two cases adult oxyurids were seen, and the Scotchtape tests were positive. Results of Kahn tests for syphilis were negative in all but one case; and in that case, old and previously treated, the reaction was 1 plus.

Problems of treatment. Operation was done in nine cases. Office treatment was administered in the others. Just as tact and patience were required in history taking, gentleness and consideration were necessary in the physical examinations. Most of the patients were somewhat tense and embarrassed. Their reactions to the examinations were sometimes feminine in quality. They disliked disrobing in front of others, including nurses, hospital aides or other doctors. The passage of the examining finger and of instruments was more of a trial for them than for heterosexual persons. They expressed great concern about the physical condition of the anorectum. Those who were operated upon recovered in normal fashion. Special care was taken not to put the more effeminate in large wards with other men, although some got along well in two-bed or three-bed wards. They were anxious to conceal their homosexuality because most of them held good positions and conducted themselves normally in the average social situation. Enemas and over-meticulous rectal preparation were avoided, and care was taken that no derogatory remarks were made by the nurses or members of the staff. Almost all the patients were easily dealt with and went through hospitalization without their homosexuality being recognized.

DISCUSSION AND CONCLUSIONS

There were so many clinical and sociological variables in this study that no unqualified conclusions can be drawn. However, it seems probable that sodomy is more prevalent than is ordinarily believed. Although the estimates made by the subjects in Group I of the number of homosexuals in the general population are undoubtedly high, the consensus that a large percentage of all homosexuals practice sodomy is significant. Statistical studies made by Kinsey, Pomeroy and Martin⁶ indicated that a relatively large number of the male white population have had some overt homosexual experience. Summarizing data on the incidence of overt homosexual experience in the white male population and the distribution of various degrees of heterosexual-homosexual balance in that population, they made the following generalizations: "Thirty-seven per cent of the total male population has at least some overt homosexual experience to the point of orgasm between adolescence and old age . . . 18 per cent of the males have at least as much of the homosexual as the heterosexual in their histories for at least three years be-

tween the ages of 16 and 55 . . . 10 per cent of all the males are more or less exclusively homosexual for at least three years between the ages of 16 and 55 . . . four per cent of the males are exclusively homosexual throughout their lives after the onset of adolescence." If, as is indicated, a considerable percentage of these homosexuals indulge in sodomy, the practice of sodomy is obviously widespread. From the present study it would also seem that sodomy is not confined to the white race, the Negro members of Group I having estimated similar frequencies for the Negro race. There is also evidence that sodomy is not uncommonly practiced by children.^{15, 16, 19}

It has also been held that passive sodomy is always unpleasant. Kinsey and co-workers¹³ said that "among males who had been stimulated anally in the homosexual, there were only a few who were particularly aroused and only an occasional individual brought to orgasm by such techniques." The present study would indicate that orgasm is quite frequently attained by passive sodomists, especially those who confine their sexual activity to sodomy.

The appearance and behavior of homosexuals in public varies, from the completely masculine-appearing athlete to the complete transvestite. Those observed in private practice are more likely to be only slightly effeminate and to behave normally. Some of them marry for the sake of appearances.

The practice of sodomy often gives rise to immediate anorectal disturbances of a relatively mild nature, as a consequence of the mechanics of the act. In many instances it is practiced with no apparent immediate ill effects. The ordinary anorectal diseases occur in these patients at a higher than average frequency than in heterosexuals of the same age. The large percentage of cases of cryptitis would indicate a high future incidence of those diseases attributed to crypt infection—fissure, abscess and fistula—in these patients.

Patulous anus, contrary to a commonly held impression, was not observed in the patients in the present study. Only two patients complained of continued gas incontinence. Control of bowel movements was apparently unaffected, but there was some change in muscle behavior as shown by the digital sign. Excess rectal intercourse may cause a short period of "looseness."

Much has been written about venereal disease of the anus and rectum.^{12, 15, 18, 19} The anal canal may be the site of chancroid, granuloma inguinale, syphilitic chancre and condyloma lata, and the anorectum may be involved in gonorrhea and syphilis. Bensaude and Lambling² described 96 male patients with lymphopathia venereum of the rectum; 82 of these patients confessed to passive sodomy. The presence of condylomata acuminata may indicate the presence of gonococci in the rectum with or without other symptoms. The finding of venereal disease in the male

anorectum may be considered presumptive evidence that the patient has practiced sodomy. Likewise, venereal disease should be looked for in all sodomists.

This study thus indicates that a considerable group of individuals practice passive sodomy and will require proctologic attention, whether in institutions or in the outside world. Likewise a considerable number of homosexuals who do not practice sodomy will develop anorectal disease. A physician's responsibility in these cases is one of diagnosis and treatment. Possible alteration of the degree of homosexuality should be left to psychiatrists. It is important that proctologists learn to recognize the homosexual, understand his problems and employ the tact and skill which will make the examination and treatment successful.

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Unusual Abdominal Cysts in Infants and Children

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INTRA-ABDOMINAL CYSTS, which always pose interesting diagnostic and therapeutic problems, occasionally are encountered in infants and children. This presentation will review abdominal cysts observed in 47 infants and children at the Los Angeles Children's Hospital from 1935 to 1954. Although these intra-abdominal cysts may form one clinical group, they should be evaluated in four pathological categories: (1) ovarian, (2) mesenteric and omental, (3) enteric, and (4) pancreatic cysts.

Of the four kinds, ovarian cysts were observed most often in the present series. Such lesions were seen in 22 cases, which was an incidence of one in 4,800 admissions and of one in 926 general surgical operations. The age range of patients was from three days to thirteen and a half years. Eight of them were 12 to 13 years old, and four of the eight had reached the menarche. Histopathologically there were five groups of ovarian cysts, as follows:

	No. of Cases	Per Cent of Total
Simple	11	51
Dermoid	4	18
Teratoma	5	23
Granulosa cell	1	4
Paraovarian	1	4

They occurred on the right side in 12 patients, on the left in seven, and bilaterally in the other three patients. Two patients with unilateral involvement had multiple cyst formation. Most cysts had a thin wall and contained fluid which was serous in all except dermoid cysts, in which it was creamy. Most were pedunculated.

Torsion of the pedicle occurred in 14 patients. In those cases, owing to strangulation and necrosis, the microscopic details were often obscured. In the cases with torsion, the symptoms were acute and of four days' duration or less.

The signs and symptoms in the group with ovarian cyst were as follows:

	No. of Cases	Per Cent of Total
Pain	20	91
Mass	17	77
Tenderness	14	64
Distention	13	59
Vomiting	11	50
Fever	9	41
X-ray evidence	[9 of the 16 cases in which x-ray examination was made]	

Part of a Symposium on Pediatric Surgery presented before the Section on General Surgery at the 83rd Annual Session of the California Medical Association, Los Angeles, May 9-13, 1954.

• In a 20-year period at the Los Angeles Children's Hospital, 46 infants and children have had operation for cysts within the abdomen. The age range of patients was from newborn to 13 years. Most of them were under four years old. There were four general groups of these cysts. (1) About one-half were cysts of the ovary, some of them serous and some dermoid. These cysts are attached by a stalk that often twists, causing gangrene or rupture with acute symptoms simulating appendicitis. (2) Next in frequency were cysts arising in the mesentery of the intestine. They usually caused little trouble until by their size (up to a 2-quart capacity) they created pressure and obstruction in the intestine. (3) Enteric cysts were found in four patients. (4) Cysts of the pancreas were present in three of the children.

X-ray examination was helpful in diagnosis. Usually the type of cyst was not determined until operation was done. Transection of the intestinal tract sometimes was necessary for removal of the cyst. Surgical correction was satisfactory in 44 of the 46 cases.

In the infant with the granulosa cell cyst there were signs of sexual precocity. In four of the nine cases in which x-ray evidence of a mass was noted, bone or tooth formation was evident. Correlation of leukocytosis with the pathological findings was possible only in the two cases in which rupture of the cyst occurred. There was history of previous trauma in two patients. One had had appendectomy for appendicitis four years previously, and the other had had inguinal herniorrhaphy two years previously, at which time a grossly normal ovary was found prolapsed into the hernial sac. Therapy in all cases was surgical removal, by salpingo-oophorectomy in 15 cases, by oophorectomy in five, and by cyst excision in two. Complications occurred in three patients with torsion of the mass. One of them (in 1937) had rupture of the cyst with peritonitis, wound dehiscence and secondary hemorrhage. She died. Of the other two, one had abdominal wound dehiscence and the other an episode of dynamic ileus. Both recovered. Thirteen patients were reexamined after elapse of varying periods after operation and nine of them were well without evident sequelae after 25

to 117 months, and the other four were well when examined one to ten months postoperatively.

Next most common in the present series were mesenteric and omental cysts. There were 18 patients with such lesions, 13 with mesenteric and five with omental cysts. The age range was from one week to six years. Ten of the patients were boys. In four cases the cysts had chylous contents. Of the five omental cysts, three were simple serous cysts, one was a teratoma and one was a degenerative sarcoma. Ten of the mesenteric cysts were situated between the leaves of the small bowel mesentery, and the other three were in the transverse mesocolon. Four of the omental cysts were in the greater omentum, and the other was in the lesser omentum. Multilocular cyst formation was present in the four patients with chylous cysts, in three patients with serous mesenteric cysts and in four patients with omental cysts. All cysts were large—having a capacity of 100 cc. to 2,000 cc. Two were hemorrhagic. Torsion occurred in two cases and in one case there was 360 degree volvulus of the jejunum.

There were no characteristic clinical manifestations. Most of the patients were asymptomatic until progressive enlargement of the cyst caused abdominal distention or pressure on other viscera. When the peritoneal reaction from pressure and necrosis was more severe, symptoms became acute, as in ten patients who had pain, tenderness and fever as prominent features. The clinical manifestations in 17 cases were:

	Twelve Cases of Mesenteric Cyst	Five Cases of Omental Cyst
Symptoms acute	11	1
Vomiting	10	1
Pain	8	4
Distention	7	4
Fever	7	2
Mass	3	2
Tenderness	6	2
Diarrhea	4	1
X-ray evidence	7	3

Surgical excision was feasible in 15 of the cases and included resection of the small bowel in two patients. In two instances, excision of a mesenteric cyst was impractical; marsupialization was carried out and after drainage for six to eight weeks there was no further complication. The patient with a sarcoma died in one year. The patient with associated bowel volvulus with diffuse damage, twice had bowel resections and abdominal drainage performed for peritonitis from a fistula, and died 27 days postoperatively. Nine patients who were reexamined were observed to be well three months to eleven years postoperatively.

Third in incidence in the series were enteric cysts (sometimes called enterogenous cysts or enterocystoma or duplication of the intestine).

In the series there were four patients with enteric

cysts. The age range was from eight months to four and a half years. Two of the patients were boys. One cyst was ileal, two cecal and one rectal in location. The cysts varied from 5 cm. to 12 cm. in diameter except for the huge rectal cyst which extended into the left upper quadrant. The rectal cyst contained feces, the others mucus. The clinical manifestations were those of gastrointestinal dysfunction. Symptoms were acute in three patients with pain and vomiting, and with associated fever in two, and tenderness in two patients. Distention was present in all cases. In two there was a palpable mass and in one of the others a mass was visualized by x-ray. The ileal and rectal cysts were excised. In one of the two cases of cecal cyst, bowel resection and ileo-transverse colostomy were carried out; in the other, treatment was by cauterization of the lining. All patients did well postoperatively. The patient who had the huge rectal cyst still had fecal incontinence after operation. The others were free of symptoms when last observed, three to fourteen and a half years postoperatively.

Three patients had pancreatic cysts, a true cyst in one case and pseudocysts in the two others. The patients were girls, two of them 15 months and one nine and a half years of age. The principal symptom was abdominal distention owing to the size of the cyst. Two patients had diarrhea and two a palpable mass. The oldest girl (who had a true cyst) had had previous episodes of acute pancreatitis proved by laparotomy, biopsy and biochemical studies. Twenty-one months before operation for the cyst, the patient had a glucose tolerance curve diabetic in type, and postoperatively the curve returned to normal. One infant had four plus albuminuria. In all cases the mass was observed in x-ray films and the site determined with the aid of contrast media. In two cases the cyst was in the lesser sac. One had a capacity of 2,200 cc. and the other of 3,500 cc. In the third case the cyst was pedunculated and contained 140 cc. Treatment was excision in two cases; and in the other, that in which the lesion was a true cyst, cystjejunostomy with jejunojejunostomy were carried out. Postoperatively a temporary ileus and wound abscess developed in one case. All the patients remained asymptomatic for 35 to 99 months after discharge from the hospital. In the girl who had cystjejunostomy, no evidence of cyst was observed in upper gastrointestinal x-ray studies.

DISCUSSION

In none of the four groups of intra-abdominal cysts were the clinical manifestations pathognomonic. The varying symptoms that did occur were usually due to the size of the cyst and its location in a site where it affected the function of the gastrointestinal

tract. The incidence of the various symptoms in the combined group of 47 cases was as follows:

	No. of Cases	Per Cent of Total
Acute symptoms	29	62
Pain	36	77
Distention	31	66
Mass	26	55
Tenderness	24	51
Vomiting	27	57
Fever	21	45
Diarrhea	10	21
X-ray evidence	23	49

Ovarian cysts usually had clinical manifestations that were acute due to torsion and infarction. (Rupture of the cyst occurred in two cases.) Only two other cysts underwent torsion, one of the mesentery, and one of the omentum. Most mesenteric cysts had acute manifestations due to bowel compression. The

patients with pancreatic cysts had mild chronic symptoms, and one had had previous episodes of acute pancreatitis.

A mass was evident in 42 of the 47 patients in the series (89 per cent) either by palpation or by x-ray. Diagnosis was made correctly on admission in 12 cases; but, in addition, cyst of an unclassified type was diagnosed in three others, and diagnosis of abdominal mass of a nature not specified was diagnosed in six other patients, making a total of 21 cases (45 per cent) in which a workable diagnosis was made before operation. Diagnoses, other than the correct one, commonly entertained were renal disease, ileus, acute appendicitis, and ascites. Diagnosis usually was not determined until laparotomy was carried out.

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CASE REPORTS

- **P. Vivax Malaria**
- **Falciparum Malaria**
- **A Complication of Pyloromyotomy**
- **Sarcoidosis**

P. Vivax Malaria

A Case with Anemia, Cardiomegaly, Hepatomegaly and Renal Involvement

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PLASMODIUM VIVAX MALARIA is a protean disease. Signs and symptoms mimicking those of acute and chronic diseases involving the liver, spleen, kidneys, blood, gastrointestinal tract, brain and respiratory system have been reported.⁵ In the present case, anemia, hepatomegaly, cardiomegaly and renal abnormalities were present.

CASE REPORT

A 29-year-old white man was admitted to Letterman Army Hospital on June 25, 1953, with diagnosis of malaria. He had served in Korea from July until December 1952, at which time he had suppressive antimalarial therapy and was evacuated because of injury to the right thumb, which had to be amputated. He was well until mid-June 1953, when he began noting gradual development of undue fatigue on moderate exertion, malaise and mild swelling of both ankles. A week later there was sudden onset of severe chills, fever, headache, low backache and mild nonproductive cough.

Upon physical examination the patient appeared to be fairly acutely ill. Oral temperature was 102.4° F., the pulse rate 96, respirations 22 per minute and the blood pressure 130/84 mm. of mercury. The skin, mucous membranes and nail beds were pale. The lungs were clear to percussion and auscultation. A Grade I pulmonary systolic murmur was present. The liver edge, which was palpated three finger-breadths below the right costal margin in the mid-clavicular line, was smooth and slightly tender. Slight pitting edema of the ankles was noted.

The hemoglobin content of the blood was 8.1 gm. per 100 cc., the packed cell volume was 26 per cent of the whole blood, the erythrocyte sedimentation rate was 21 mm. in one hour (Wintrobe method) and leukocytes numbered 4,300 per cu. mm.—41 per

cent neutrophils, 52 per cent lymphocytes, 6 per cent monocytes and 1 per cent eosinophils. The mean corpuscular volume was 98 cubic micra, the mean corpuscular hemoglobin was 31 gamma gamma, and the mean corpuscular hemoglobin concentration was 31 per cent. The reticulocyte count was 6 per cent the day after admission. P. vivax was observed upon examination of a specimen of blood.

Upon microscopic examination of the urine on the day of admittance a trace of albumin, 4+ reaction for occult blood and numerous leukocytes were noted. A week later, urinary concentration, Addis counts and the urea nitrogen content of the blood were normal. On June 26, a sulfobromophthalein test was done and there was retention of 6 per cent of the dye after 45 minutes. On June 27 the serum bilirubin was 0.1 mg. per 100 cc. at one minute and 0.4 mg. after 30 minutes. The urinary urobilinogen excretion in two hours was 1.6 Ehrlich units (Table 1).

A roentgenogram of the chest showed the heart grossly enlarged as compared with a film taken during the previous hospitalization in February 1953. The transverse diameter now was 159 mm., an increase of 48 mm. (Figure 1). Repeated electrocardiograms were interpreted as normal. Routine stool examinations revealed ova of ascaris lumbricoides on several occasions. No occult blood was present.

On admission the patient received a single dose of 0.8 mg. of amodiaquine hydrochloride (Camoquine), and the temperature, pulse and respirations promptly returned to normal. Certain unusual features were apparent: Moderately severe anemia of recent origin without evidence of internal or external hemorrhage, hepatomegaly, cardiomegaly with ankle edema and microscopic hematuria and pyuria. On special investigation of the cardiovascular-renal system no gross abnormality was noted. The venous pressure was 120 mm. of water and the Decholin arm-to-tongue circulation time was 15 seconds. The pulmonary systolic murmur disappeared, the ankle edema subsided, and the liver edge receded by the fifth hospital day. Slowly the hemoglobin content of the blood returned to normal and the heart size decreased (Figure 1 and Table 1). A two-week course of primaquine was given without untoward

From the Department of Medicine, Letterman Army Hospital, San Francisco.

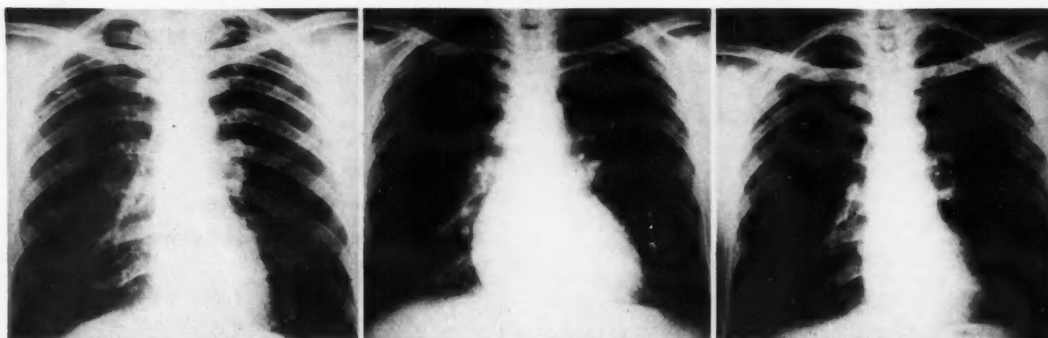


Figure 1.—*Left*, routine x-ray film of chest taken at time patient was hospitalized in February, 1953, for surgical procedure. Transverse diameter was 101 mm. *Center*, taken June 26, 1953, one day after admission to hospital for *P. vivax* malaria. Transverse diameter was 159 mm. *Right*, three weeks later, transverse diameter was 119 mm.

TABLE 1.—Laboratory findings

	April 1953	June 25, 1953	June 30	July 7	July 14	July 21
Hemoglobin (gm.).....	14.9	8.1	9.7	10.7	14.4	14.0
Reticulocytes (per cent).....		6.0	1.8	0.9	0.9	1.0
Cephalin Flocc.						
24 hour.....			3 plus	2 plus	1 plus	1 plus
48 hour.....			4 plus	3 plus	2 plus	1 plus
Thymol turbidity (units).....			14	10	9	7
Serum globulin (gm. per 100 cc.).....			4.2	4.9	4.3	4.2
Serum albumin (gm. per 100 cc.).....			2.0	3.4	3.7	3.5
Urine analysis						
Albumin.....	None	Trace	None	None	None	None
Erythrocytes per high power field.....	0	Numerous	3-4	0	Rare	2-4
Leukocytes per high power field.....	0	Numerous	1-2	0	1-2	2-4
Casts.....	0	0	3-4	0	0	0
			hyaline and granular casts			
Transverse cardiac diameter (mm.).....	101	159	146	130	119	127

reactions. After this, the mild *ascaris lumbricoides* infestation was treated with hexyl resorcinol crystals. The patient returned to his former physical condition and was discharged from the hospital 50 days after admission.

DISCUSSION

Despite the fact that all United States military personnel in the Far East receive 0.5 gm. of Chloroquine each week as suppressive antimalarial therapy, plus two weeks of curative therapy with Primaquine (15 mg. per day) en route home via ship, a few cases of *P. vivax* malaria have been seen at various military and civilian hospitals.⁴

The patient in the present case had symptoms of malaise, weakness and the unusual feature of swelling of the ankles for about one week before the onset of classical chills and fever. However, in addition, he had severe anemia, cardiomegaly, hepatomegaly, hypoalbuminemia, albuminuria and abnormal cellular elements in his urine. These abnormalities all abated within a week during which the only medication was a single dose of Camoquine.

The anemia in *P. vivax* malaria is attributed to erythrocyte destruction caused by the malarial parasite and is usually normocytic and normochronic. It

may be owing in part to the toxic inhibition of bone marrow activity, for the reticulocytes which are low during the active phase increase temporarily after the parasites are destroyed by therapy. This inhibitory effect is also suggested by the leukopenia present.⁹ The lack of pronounced changes in the serum bilirubin and urinary urobilinogen in the present case would indicate that either the active phase of hemolysis was over by the time the test was done or no hemolysis was present. That there was a marrow inhibitory factor was strongly supported by the finding of an increase in reticulocytes after therapy, and persistent leukopenia. The presence of anemia in patients with *P. vivax* malaria is variable; it occurred in only two out of ten patients with the disease who were observed at the same time as the patient in the present case.

In a review of the literature no previous reports of cardiomegaly in cases of malaria were found. In the present case the anemia may have been the predisposing factor, although Porter and James⁷ pointed out that cardiac enlargement is usually seen in chronic anemia but that if present in acute anemia it is a result of the presence of other cardiovascular disease such as hypertension, arteriosclerosis or valvular disease. None of these factors was present in

the present case and there was no evidence of congestive failure.

Ankle edema has been previously noted in *P. vivax* malaria and has been ascribed to the low serum albumin that is often observed.² The latter is a result of changes in the reticuloendothelial system, primarily in the liver, which together with the increased globulin account for the abnormalities in results of liver flocculation tests.⁶

Finally, albuminuria, cylindruria and microscopic hematuria and pyuria may be due to the alterations reported pathologically in the renal glomeruli and tubules.¹ These are not common in *P. vivax* malaria and when present are transient, mild and reversible. Renal disease varying from that typical of nephrosis, seen mainly with *P. malariae* malaria, to renal failure secondary to hemoglobinuria due to *P. falciparum* malaria, has also been reported.^{3, 8}

SUMMARY

An unusual case of *P. vivax* malaria, with anemia, cardiomegaly, ankle edema, hepatomegaly and renal

involvement, has been reported. The mechanisms have been discussed.

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Falciparum Malaria

Report of a Fatal Case and Autopsy Findings

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MALARIA, although considered to be one of "humanity's chief scourges"² is an uncommon disease in the civilian populace of California. In Los Angeles County, for example, the median incidence of this disease in a five-year period (1948-1952) was one case per year.⁴ In most of these cases the causative organism was *Plasmodium vivax*. Malaria due to *P. falciparum* is rare; in all California only one case in 1953 and only two in 1952 (one of which was listed as "probable") were reported to the Bureau of Acute Communicable Diseases.⁷ Moreover, symptomatic responses to falciparum malaria are much less distinctive than those to vivax or quartan infections and frequently offer little help in reaching a presumptive diagnosis. A disease that is rare and without distinctive features presents a formidable diagnostic problem. In the case here presented the disease was successively presumed to be influenza, intestinal obstruction and acute cholecystitis before a correct diagnosis was made on the basis of observation by an alert laboratory technician.

REPORT OF A CASE

A 65-year-old woman had fever, lassitude, generalized arthralgia and myalgia of three days' duration. Chilly sensations had been present at the onset, for a few hours only. The patient had returned from a vacation in Mexico only a few days before be-

coming ill. On questioning she said that she had been in a region where malaria is endemic but that rainfall had been unusually light and there had been no mosquitoes about.

The body temperature was 101 degrees F. A provisional diagnosis of influenza was made and symptomatic therapy was prescribed. The patient was not improved the following day, and since she lived alone she was admitted to the hospital for care. The body temperature at the time of admittance was 99.4 degrees F., the pulse rate was 70, respirations were 22 per minute and the blood pressure was 146/88 mm. of mercury. There was slight tenderness in the right upper quadrant of the abdomen and very slight abdominal distention.

On the second hospital day, the patient awoke very nauseated and vomited a small amount of clear fluid containing brownish flecks which by chemical test were found to contain blood. She also complained of severe abdominal pain; and an increase in abdominal distention and some diffuse abdominal tenderness was noted. The body temperature was subnormal most of this day. Because of the many stab cells and diminished number of platelets noted on examination of the blood the day of admittance, the pathologist requested additional specimens (see Appendix A—additional laboratory data). These were taken on the third hospital day but revealed nothing diagnostic. Abdominal pain and distention continued and the patient was not able to retain even liquids by mouth. The possibility of intestinal obstruction was considered. A plain film of the abdomen showed a large amount of gas in the large bowel and also in the right upper quadrant a pyriform shadow of increased density, which was con-

sidered to be the gall bladder. In view of the pronounced distention of the colon, a barium enema was given but as no obstructive lesion was demonstrated it was concluded that the distention might be owing to ileus.

During the fourth and fifth hospital days the temperature fluctuated between 96.8 degrees F. and 102.4 degrees F.; the abdominal symptoms and signs persisted. Shortly after midnight of the sixth hospital day the patient, awakened by severe epigastric pain, became nauseated and vomited several mouthfuls of brownish, mucoid liquid. The blood pressure at that time was 78/50 mm. of mercury. The patient was quite apprehensive and dyspneic and the rate of respirations was 36 per minute. The abdomen was more distended. Peristaltic sounds were hyperactive and there was definite tenderness in the right upper quadrant of the abdomen. A surgical consultant who examined the patient at this time was able to outline a mass in the right upper quadrant which he believed was an acutely inflamed gall bladder surrounded by omentum. He felt that the patient had acute cholecystitis, but in view of the duration of the process recommended conservative management. During this day, the temperature rose to 102.6 degrees F. The patient appeared restless but quite weak. The abdominal symptoms continued.

A laboratory technician, examining a specimen of blood on the sixth day for a routine determination of the numbers of cells, observed numerous malaria parasites. Upon further study they were observed to be predominantly multiple ring form trophozoites with occasional shizont forms and infrequent crescent-shaped gametocytes typical of *Plasmodium falciparum*. Administration of quinacrine, 0.2 gm. every six hours, was started on the seventh day and a total of 0.8 gm. was given. The patient was able to retain this medication but on this day she had a chill with a rise in temperature to 101.6 degrees F., and there was no decrease in the number of parasites observed in a specimen of blood.

On the eighth day the patient became very dyspneic and had some bronchial wheezing and audible rales at both lung bases. The temperature reached 103.2 degrees F. Icterus was noted for the first time and also a large area of ecchymosis in the lumbar region was observed. A total of 3 gm. of chloroquine was given on the eighth and ninth days, of which the patient retained approximately 2 gm. During the ninth day icterus became more intense and for the first time the patient was somnolent, although easily aroused, and even though obviously gravely ill, she was rational and oriented. The temperature during the ninth day fluctuated between 99.0 degrees F. and 101.8 degrees F. However, the output of urine dropped precipitously to 565 cc., despite an intake of liquids of 2900 cc. Several specimens of urine were deep brown in color and thick in consistency. Two smears of specimens of blood taken about twelve hours apart on this day revealed the parasites were still numerous. Quinine dihydrochloride, 3 gm. intravenously, was given on the ninth and tenth

days. On the morning of the tenth day rather profuse epistaxis occurred. Respirations were 16 per minute with the patient at rest, but upon very slight exertion rose to 24 to 28 per minute. The maximum temperature during this day was 101.0 degrees F. The urinary output increased to 820 cc. in 18 hours, and the urine was not so dark as on the previous day. Basal rales and infraorbital and pretibial edema were noted. In the evening the patient was rather comfortable and appeared somewhat improved over the previous day. However, at 11 p.m. a Jacksonian seizure involving the left hand and left leg occurred. It was rapidly followed by generalized convulsion and the patient died.

AUTOPSY

Macroscopic: There was pronounced jaundice of the skin and sclerae. Each of the pleural cavities and the peritoneal cavity contained approximately 500 cc. of yellowish-pink serous fluid. The lungs were moderately congested with frothy reddish-yellow fluid pouring freely from the opened bronchi. There was obvious splenomegaly and hepatomegaly. The spleen, which weighed 350 gm., showed a soft, mushy, dark reddish-purple pulp in which the malpighian corpuscles were not discernible. The liver, which weighed 2,250 gm., had finely mottled, reddish to yellowish-brown cut surfaces of soft consistency. The gall bladder was normal. There was generalized enlargement of lymph nodes, involving particularly the periaortic and mesenteric lymph nodes, which were firm and on cut surfaces were mottled reddish to pinkish-gray. There were a few petechial hemorrhages on the mucosal and serosal surfaces of the stomach and duodenum. The brain substance was slightly edematous and had a faintly yellow cut surface. There were no demonstrable petechiae. The vessels of the leptomeninges appeared slightly congested. The iliac bone marrow was dark reddish-gray. In the remainder of the organs no significant gross abnormalities other than moderate congestion were noted.

Microscopic: Conspicuous changes, chiefly in the liver, spleen and kidneys, were observed.

In the spleen there was loss of normal histological architecture with marked vascular congestion of the sinusoids. The latter were filled with hemolyzed red cells, large mononuclear cells and macrophages laden with yellowish-brown pigment granules and nuclear debris. A few parasitized red cells were demonstrable.

There was evidence in the liver of pronounced parenchymatous degeneration with vacuolization and cloudy swelling of the hepatic cells. The sinusoids were dilated and filled with numerous small round cells, pigment-laden macrophages and parasitized red cells.

In the kidneys moderate parenchymatous degeneration of the tubular epithelium was noted. The tubules contained yellowish-pink granular casts. Similar amorphous pink-staining granular material

was also present in the subcapsular spaces of the glomeruli which were otherwise not remarkable.

There was minimal glial and perivascular edema throughout the cerebral cortex. Parasitized red cells were demonstrable in the capillaries and larger vessels. In addition, there were scattered pigment-laden macrophages throughout the glial substance.

There was moderate vascular congestion in the lungs, with parasitized red cells demonstrable in the capillary lumina.

Upon examination of sections from the iliac crest, hyperplastic marrow with an increase of erythroid and myeloid elements was noted. Parasitized red cells and pigment-laden macrophages were numerous and abundant.

DISCUSSION

Malarial infections have a predilection for organs of the reticuloendothelial system, namely, the liver, spleen, bone marrow and lymph nodes.¹ When macrophages of these organs fail to localize the infection, parenchymatous degeneration may take place in several organs. This is due either to the rapid blood destruction and anemia, or to thrombosis of capillaries, apparently occurring as a result of the agglutination of parasitized erythrocytes.⁶ Although such cells were widespread in the vascular spaces of virtually all tissues examined in the present case, thromboses were not seen, possibly owing to the decreased prothrombin content and thrombocytopenia. Hence, it was assumed that the parenchymal damage noted particularly in the liver and kidneys was related to anoxia resulting from hemolysis and anemia.

Covel³ recently wrote: "There is no known disease which may simulate as many other ailments as falciparum malaria. . . ." Since the experience with the case reported herein, however, the authors have learned that the clinical features observed in the patient—high, irregular fever, nausea, vomiting, abdominal pain and distention, jaundice and epistaxis—are quite characteristic of a type of falciparum malaria well known to malariologists as "bilious remittent fever."^{5, 8, 9} Unfamiliarity with this syndrome and consequently the delay in making the correct diagnosis, as well as the age of the patient, the type of infection and the resistance to substantial doses of three anti-malarial drugs were all contributing factors to the fatal outcome.

SUMMARY

A fatal case of "bilious remittent fever" type of *P. falciparum* infection is presented. It was successively presumed to be influenza, intestinal obstruction and finally cholecystitis before a correct diagnosis was established.

511 So. Bonnie Brae.

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APPENDIX "A"—ADDITIONAL LABORATORY DATA

First day: Hemoglobin, 14.1 gm. per 100 cc.; erythrocytes, 4,430,000 per cu. mm.; leukocytes, 4,400 per cu. mm. with 85 per cent polymorphonuclear cells (76 non-filamented, 9 filamented), and 15 per cent lymphocytes; platelets, fewer than normal. Results of urinalysis were within normal limits except for mild pyuria. No abnormality seen in x-ray film of chest.

Third day: Erythrocytes, 4,700,000 per cu. mm.; leukocytes, 5,000 per cu. mm.—80 per cent polymorphonuclear cells (33 non-filamented, 47 filamented), and 20 per cent lymphocytes; platelets, 85,000 per cu. mm.

Fifth day: Result of test for occult blood in stool, positive.

Sixth day: Serum amylase, 35 units per 100 cc. (normal 40—110 units); serum lipase, 100 units (normal 85—205 units); hemoglobin, 12.9 gm. per 100 cc.; erythrocytes, 3,820,000 per cu. mm.; leukocytes, 6,100 per cu. mm.—83 per cent polymorphonuclear cells (45 non-filamented, 38 filamented), 16 per cent lymphocytes and 1 per cent monocytes. An electrocardiogram indicated left ventricular strain.

Eighth day: Erythrocytes, 2,930,000 per cu. mm.; platelets, 58,000 per cu. mm. Prothrombin: Patient's time, 38 seconds; control, 16 seconds; prothrombin content, 16 per cent. Serum bilirubin, 5.4 mg. per 100 cc. direct and 0.7 mg. indirect.

Ninth day: CO₂ combining power, 23 volumes per cent. Prothrombin: Patient's time, 27 seconds; control, 15 seconds; prothrombin content, 26 per cent. Whole blood chlorides, 516 mg. per 100 cc.

Tenth day: Prothrombin: Patient's time, 19 seconds; control, 15 seconds; prothrombin content, 60 per cent. Erythrocytes, 3,120,000 per cu. mm.; hemoglobin, 10.0 gm. per 100 cc.; leukocytes, 8,000 per cu. mm.—77 per cent polymorphonuclear cells (38 non-filamented, 39 filamented) and 23 per cent lymphocytes.

A Complication of Pyloromyotomy

Recovery After Perforation of Duodenum

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HARVEY N. LIPPMAN, M.D., Los Angeles

ACCIDENTAL PERFORATION of the duodenal mucosa during Fredet-Ramstedt pyloromyotomy for hypertrophic pyloric stenosis is the most common and most feared complication of this operation. The reported incidence ranges from as low as one in 385 operations¹ to as high as 28 in 110 cases.³ It is not a serious accident if the opening is seen when it is made and is sutured.² However, if not discovered, the continuing escape of duodenal contents will almost invariably result in fatal peritonitis. In a review of the literature no report was found of a proved case in which a patient survived unrecognized perforation. The purpose of this report is to present the case of an infant with unrecognized perforation who survived.

REPORT OF A CASE

The patient, a male infant, was operated upon elsewhere for hypertrophic pyloric stenosis at two months of age. The usual Fredet-Ramstedt procedure was done, permitting the mucosa to bulge into the wound. A small venous bleeding point at the duodenal end of the incision was noted but was not ligated. The highest temperature was 102° F. on the first postoperative day. The patient was discharged on the fifth day with a normal temperature and retaining feedings. No antibiotics were administered during the hospital course.

The infant was admitted to the Los Angeles County Harbor General Hospital 11 days after the operation. The mother stated that four days previously (two days after discharge from a private hospital following the above described operation) the patient began to vomit infrequently and in small amounts. The abdomen became increasingly distended and no bowel movements were noted. Vomiting increased in frequency and the vomitus, at first bile-stained, later became thick, greenish-yellow and had a "bitter odor."

The patient was extremely emaciated and dehydrated, and the pattern of hugely distended loops of bowel was visible through the anterior abdominal wall. No masses, rigidity or tenderness were noted. Bowel sounds were infrequent and high-pitched. No abnormality was noted in rectal examination. Results of laboratory examinations of the blood and urine were within normal limits. A roentgenogram of the abdomen showed several parallel loops of greatly distended bowel with an appearance compatible with mechanical obstruction of the small bowel.

At operation, with the patient under local anesthesia, greatly dilated loops of small bowel were observed. In the right subhepatic space there was an abscess, containing approximately 4 cc. of bile-stained pus, that was connected with a 2 mm. opening in the duodenum at the distal end of the partially

healed pyloromyotomy wound. Bile-stained fluid was easily expressed from the perforation, which was closed with two through-and-through sutures of No. 00000 gastrointestinal chromic catgut. Fibrinous peritonitis involved all the right peritoneal gutter and many loops of adjacent small bowel. The point of obstruction was about 6 inches proximal to the ileocecal valve. The obstruction was relieved by sharp and blunt dissection and the dilated bowel was decompressed by suction enterotomy. It then became evident that a segment of ileum was not viable. Eighteen inches of nonviable and denuded ileum were excised. An open end-to-end anastomosis was done, using an inner row of No. 00000 chromic catgut and an outer layer of interrupted Lembert sutures of No. 00000 silk. The bowel was returned to the peritoneal cavity and, in the belief the patient was near death, the abdomen was hurriedly closed with through-and-through retention sutures of No. 30 steel wire.

That the patient lived was attributable largely to excellent postoperative care by the pediatric staff. Convalescence was retarded because of healing of the skin incision by second intention. By the twenty-second postoperative day the patient had gained 2 pounds in weight and was getting along satisfactorily. On the forty-third postoperative day he was discharged. The body weight then was 10 pounds. At the age of seven and a half months it was 18 pounds and the patient was apparently eating and developing as any normal child.

COMMENT

Perforation in this case was discovered only because intestinal obstruction developed. In this instance it may be significant that there was bleeding at the distal end of the Fredet-Ramstedt pyloromyotomy site during the original operation. Szilagyi and McGraw⁴ pointed out that there is a deep artery and vein running across the duodenal end of the incision at the fornix of the duodenal mucosa, thus indicating the danger area. The hypertrophied pyloric musculature extending into the duodenal lumen can be likened to the uterine cervix extending into the vaginal canal. Consequently, the incision into the hypertrophied pylorus can easily nick the duodenal mucosa if carried too far distally or too deeply. If there is any suspicion of mucosal injury, attempts should always be made to discover them at the time of operation. There are three methods of demonstrating such perforations: (1) simple observation of the hole in the mucosa emitting bubbles of bile-stained fluids; (2) compression of the stomach and duodenum in an effort to force gas or fluid through a minute perforation; (3) with the duodenum compressed injection of air or methylene blue through a catheter in the stomach in an effort to force fluid or gas through the minute perforation. The use of a binocular loupe may aid vision in this area. Once the perforation is found, simple closure with fine catgut or silk sutures on an atraumatic needle solves the problem. Other methods have been suggested but are probably unnecessary.

From the Los Angeles County Harbor General Hospital.

The infant in the present case survived three highly lethal mechanisms—duodenal perforation, intestinal obstruction and small bowel resection. The present-day medical armamentarium of scientific management of fluid and electrolyte balance, antibiotics, blood transfusions, trained anesthetists, and pre- and postoperative care by pediatricians encourages surgeons to intervene in seemingly hopeless problems with some expectation of success.

211 Cherry Avenue.

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Sarcoidosis

A Diagnostic Problem

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BOECK'S SARCOID is usually considered a benign, self-limited disease that in most cases leaves little if any residual damage. Often the disease is entirely asymptomatic and is detected fortuitously on routine x-ray examination of the chest. In the present case, however, sarcoidosis presented a diagnostic problem in an acutely ill patient.

During an acute febrile illness with definite or indefinite evidence of abnormality in the chest on x-ray examination, it is important to consider the following in differential diagnosis: (1) virus pneumonitis; (2) bacterial pneumonitis; (3) Hodgkin's disease; (4) bronchiogenic carcinoma; (5) collagen disease; (6) tuberculosis; (7) granuloma (Boeck's or Wegener's). Although it is well known that usually in sarcoid disease there is involvement of the hilar nodes and lungs, the diagnosis cannot be made from roentgenologic observations alone, for Boeck's sarcoid can simulate pulmonary disease of almost any kind. Laboratory findings that aid in making the diagnosis are: (1) elevation of serum protein and globulin values; (2) accelerated sedimentation rate; and (3) a negative reaction to tuberculin. Elevation of the blood calcium level and increased alkaline phosphatase activity have been reported in a few cases but are not constant findings. Of course, if there are skin lesions or peripheral node enlargement, biopsy of material from these lesions is the most accurate method of diagnosis. The Kveim antigen injected intracutaneously is highly specific for sarcoidosis, its only disadvantage being the length of time required for a nodule to form and then for biopsy. When the diagnosis is uncertain and no peripheral nodes are present, needle biopsy of the liver may give positive evidence of sarcoidosis.

REPORT OF A CASE

A white man 58 years of age was first observed February 10, 1953, with complaints of morning and afternoon fever (101° F.), considerable nausea, lack of appetite and "cigarette" cough—all of about three weeks' duration. (He stopped smoking soon afterward and the cough disappeared.)

Upon examination, tachycardia was noted and the temperature was 100.6° F. Fluoroscopic examination of the chest was carried out and a fairly well defined strand of density extending from the lower hilar area to the periphery of the right lower lobe was observed. The blood sedimentation rate (Linzenmeier) was 18 mm. in 30 minutes. Penicillin was given, 600,000 units a day for a period of one week, and during that time the temperature reached 104° F. on several days, associated with chills. As the patient refused to enter the hospital for further study, penicillin was discontinued and aureomycin, 1 gm. per day, was administered. The patient felt worse and had considerable nausea. In the afternoons and evenings the body temperature rose to 102° F. to 103° F. During a two-week period the abnormalities noted were a few dry rales at the right lung base posteriorly, persistent tachycardia, 4 plus albuminuria with granular casts and accelerated blood sedimentation rate. An additional patch of density originating near the left hilum and extending toward the left base was observed fluoroscopically. At no time was any degree of dyspnea noted, although on several occasions the lips were cyanotic.

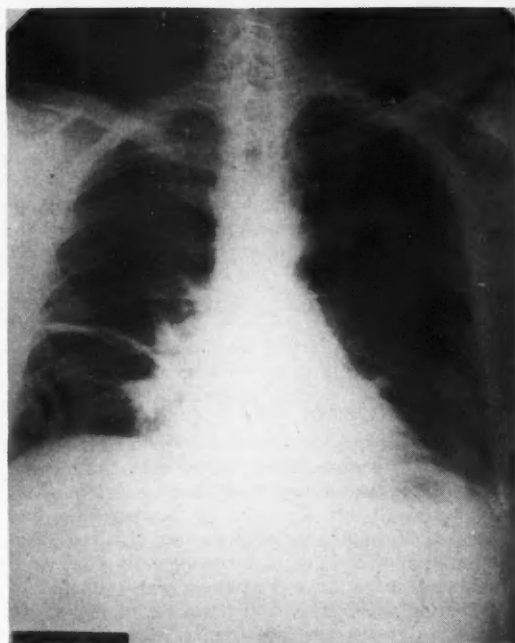


Figure 1.—Linear strand of density extending from right hilum to periphery, with beginning involvement of left hilar area.

After three weeks the patient consented to hospitalization, and various laboratory studies were carried out. Reaction to dermal test with tuberculin was negative on two occasions. No organisms were seen on examination of smears of the sputum and none grew on cultures. There was negative reaction to a test for cold agglutinins. A heavy trace of albumin was noted in the urine. No organisms grew on cultures of the blood. Results of serological tests for Q fever and influenza A and B were negative. Erythrocytes numbered 4,500,000 per cu. mm. and leukocytes 10,900 with normal differential of cells. The content of non-protein nitrogen in the blood was 38.0 mg. per 100 cc., of albumin 3.6 gm. and of globulin 3.4 gm. per 100 cc. Save for tachycardia, an electrocardiograph was normal. No abnormality was observed in roentgen studies of the upper and lower gastrointestinal tract.

Streptomycin and penicillin were given in combination and, although the patient did not become entirely afebrile, in several weeks the temperature tapered off to 100° F. at midnight nearly every day. Nausea increased and appetite was poor, especially for meats.

After some time, slight enlargement of a lymph node high in the left axillary area was noted. Whether or not the liver was enlarged was questionable. At no time was the spleen palpable.

Refusing to have bronchoscopic examination and biopsy of a supraclavicular node, the patient was discharged and use of antibiotics was discontinued. Extreme nausea persisted, the temperature rose to 101° to 102° F. daily and the body weight decreased 35 pounds in two months despite a high caloric liquid diet. Rales were heard upon auscultation from time to time, but never was dyspnea noted. The sedimentation rate remained rapid. In x-ray films the left lower lung field appeared to be clearing but there were still strands of abnormal density present at the base of the right lung. Clinically the patient was not improving.

Three months after the onset of the acute symptoms, the patient consented to operation. Bronchoscopic examination and exploration of the right supraclavicular fat pad were done and no abnormalities were noted. Upon thoracotomy no evidence of tumor in the lung was seen. A lymph node was removed from the lateral tracheal area, the supraazygous area and the corynal area and the pathologist's report was "Boeck's granuloma with considerable anthracosis."

The patient quickly convalesced from the operation and was sent home, again without medication. Fever, anorexia, nausea and chilly sensations resumed immediately. By then the body weight had decreased 55 pounds since the onset of illness. Administration of 100 mg. of cortisone daily was begun and within a few days the patient was afebrile and was eating well. The body weight increased 16 pounds in two weeks, apparently without extraordinary fluid retention. When the dosage of cortisone was reduced to 50 mg. daily the temperature rose to a high point of 101° F. daily although the patient

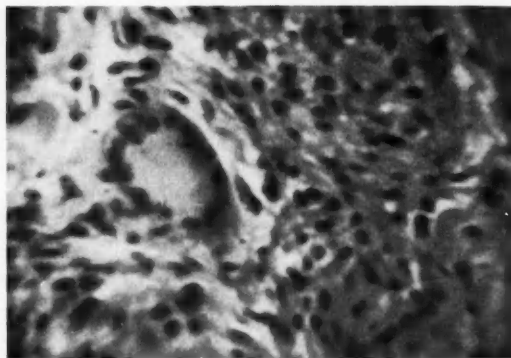


Figure 2.—Specimen removed from hilar lymph gland showing rather typical sarcoid involvement.

felt quite well. The amount given was raised to 100 mg. daily again and the fever abated until, after six weeks of cortisone therapy, the patient again began to have occasional fever (101° F.) associated with a chill. The amount of cortisone then was gradually reduced and 20 units of corticotropin (ACTH) gel was given daily. Again the fever stopped, but after six or seven days it resumed, rising to 100 to 101° F. The patient had a feeling of well-being and the body weight and appetite were well maintained. The blood sedimentation rate was still rapid, however (18 mm. in 10 minutes, Linzenmeier) and there were occasional chills and fever, indicative that the disease was still active. Seven months after the onset of the disease, the patient still had temperature as high as 103° sometimes but was otherwise asymptomatic as long as either cortisone or corticotropin was given.

DISCUSSION

It is important to consider sarcoidosis in any case in which fever is associated with unusual x-ray findings in the lung. Thoracotomy is being used more now as a method of diagnosis in questionable cases of sarcoid, but of course it should be avoided if a diagnosis can be made by other more simple methods. It is of paramount importance to arrive at the diagnosis early in the course of the disease, in order to assure the patient he does not have malignant disease and also to avoid an unnecessary surgical procedure. The toxicity of sarcoidosis can be decreased considerably by the use of cortisone and corticotropin, but it is doubtful that these agents shorten the course of the disease.

SUMMARY

In a patient with nausea, fever, anorexia, loss of weight and pulmonary changes noted in auscultation and on x-ray films, Boeck's sarcoid disease was not diagnosed until biopsy of lymph nodes was carried out. Administration of cortisone and corticotropin, after diagnosis was established, relieved the symptoms but apparently the disease was not cured.

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California MEDICINE

For information on preparation of manuscript, see advertising page 2

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EDITORIALS

New Industrial Fees

AT LONG LAST the Industrial Accident Commission of the State of California has adopted a new schedule of medical and surgical fees for industrial accident cases.

The new schedule will go into effect on October 1 and will provide an increase of something more than 15 per cent over present fees. Translated into terms of dollars, this means that the physicians of California will come about two and a half million dollars a year closer to realizing fair and compensatory fees for treating the thousands of patients who are injured or become ill each year owing to the nature of their employment.

Action by the Industrial Accident Commission in adopting the new schedule came after 17 months of consideration of an application filed by the California Medical Association. The original application asked for fee increases to produce about a 36 per cent increase in aggregate fees. This requested rise was indicated by a comparison of numerous business indices, including the cost of living index, cost of maintaining an office, increases in wages and other factors. The Association believed it had sound reason to ask for this increase in an effort to bring industrial fees into line with fees paid by all other elements of the community.

Before filing of the current application with the Commission, the C.M.A. committee had been met with the official attitude of the Commission that it had no distinct legal authority to promulgate, adopt or maintain a schedule of medical and surgical fees. This decision by the Commission left the C.M.A. in the position of having to negotiate an improved fee schedule with the insurance carriers. Negotiations along this line were undertaken but, as might be expected, the insurance companies were not particularly anxious to agree to a new set of fees that

would increase their costs. In this atmosphere, the two-way bargaining dragged.

Early in 1953 the C.M.A. caused a bill to be introduced into the State Legislature to spell out the legal authority of the Industrial Accident Commission to establish a schedule of medical and surgical fees. Labor and insurance interests agreed with the philosophy of this measure, and it was adopted and signed into law. This meant that as of last September the position of the Industrial Accident Commission was clearly defined; the Commission did have the authority which it felt it had previously lacked.

The new law provided that the Commission must hold public hearings before adopting a medical fee schedule. Such hearings were arranged, all interested parties were notified and three public hearings were held. The California Medical Association went into these sessions in mutual agreement with the insurance industry. Months of meetings had finally produced a schedule which the insurance negotiating committee had approved. The estimated increase in cost to insurance companies was approximately 19.1 per cent.

Then, when the sessions began, employer representatives questioned the percentage of increase requested. In addition, certain labor elements threw up a smoke screen by insisting that each individual item changed in the new fee schedule be justified by the Medical Association. These two elements caused the negotiations to be prolonged and difficult.

Now that the Industrial Accident Commission has taken official action, as of next October 1 all industrial injury cases will be handled on the basis of the new fee schedule.

Before the effective date of the new schedule, the C.M.A. will distribute copies of the fees to all its members. The insurance industry will circularize its members with copies of the schedule. These mailings should go far toward eliminating some of the mis-

understanding and the ambiguities that have accompanied the present schedule.

The California Medical Association is deeply indebted to Dr. Francis J. Cox and his committee. These men have labored for close to four years to gain acceptance of a more adequate industrial fee schedule. While the list to go into effect in October does not realize the committee's sincere belief as to a proper level of fees, it is a long step in the right

direction. The committee has realized a gratifying increase in industrial fees; it has opened the legal door to adoption and approval of an industrial schedule. On the more philosophical side, the committee has learned many of the techniques needed to negotiate, fight for and win more adequate fees for physicians.

With this background, future adjustments should come with greater facility.

California MEDICAL ASSOCIATION

NOTICES & REPORTS

Cancer of the Female Genital Tract

*Recommendations of the Cancer Commission
of the California Medical Association*

THE MOST COMMON CANCER of the female genital tract is cancer of the cervix of the uterus. For practical clinical purposes, this is regarded as an accessible cancer and, when properly treated, should yield approximately 40 per cent five-year clinical cures in an unselected group of patients reporting for treatment. If the condition is diagnosed when it is confined strictly to the cervix, the five-year clinical cure rate is approximately 90 per cent. This form of cancer is therefore a curable form and the responsibility of the medical profession correspondingly great.

The Cancer Commission of the California Medical Association issued its first recommendations on the diagnosis and treatment of cancer of the female genital tract in 1936,¹ and a new edition of these studies was published in 1950.² In both studies it was stressed that the vast majority of cases of cancer of the cervix should be treated primarily by radiation therapy. Only in the earliest cases should operation be considered in primary treatment. Since many apparently early or small lesions have already spread to surrounding tissues or produced metastases, many experienced physicians treat *all lesions* by radiation therapy as a primary step.

In the 1950 edition, the Editorial Committee for the Cancer Commission stressed that, "Radiation therapy remains the treatment of choice in practically all cases of cancer of the cervix."

In 1954, the American Cancer Society, National Division, New York City, published monograph No. 8, "Cancer of the Female Genital Tract." There are many excellent diagnostic sections in this monograph. However, the sections on treatment represent opinions so at variance with those of the Cancer Commission and those published in the two editions of Cancer Commission Studies, that the Commission wishes to bring to the attention of all physi-

cians practicing in California its considered opinion that the therapeutic recommendations issued in this monograph should *not* be followed by physicians practicing in this state. Some specific comments on the treatment divisions of the monograph are as follows:

Cancer of the Cervix. The monograph states that "If the lesion is small and the patient young, that is less than 35 years, irradiation is not employed." Comment: The term "small" has no scientific connotation. It may apply to cervical lesions classifiable as Stage II, III or IV. Under average conditions of practice, competent radiotherapy gives superior cure rates to radical operation even in Stage I lesions of the cervix. Therefore, the Cancer Commission still recommends radiotherapy as the primary treatment in the vast majority of cases.

The monograph says further: "Visibly ulcerated lesions, be they Stage I, II, III or IV, should first be treated by radiation . . . When the local lesion has healed, and the patient is convalescent, the further treatment is considered . . . A fair number of patients with Stage I lesions and some with Stage II who are treated by radical hysterectomy will be found to be in good general health . . ." The Com-

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mission does *not* believe that radical hysterectomy should routinely follow competent, adequate radiotherapy of Stage I and II lesions, or, for that matter, any other lesions.

In various portions of the monograph, statements are made concerning specific radiotherapeutic dosages from external roentgen rays, radium, and other radioactive sources. The Commission is informed that these statements are the opinions of the two physicians who prepared the monograph, and were not submitted to nor edited by the radiotherapists attached to the institution from which the monograph came. The Commission believes it would be just as unwise for a radiotherapist to specify surgical technical details with which he is not intimately familiar, as it would be for other physicians to express radiation dosages in form too brief for safe employment.

For the latest year for which mortality data are available (1950), deaths due to cancer of the uterus

corpus and cervix) on the national level amounted to 16,085, and in California to 1,041. By competent treatment, this death toll could unquestionably be greatly reduced. In fact, from 1930 to 1950 mortality from carcinoma of the uterine cervix in California decreased from 29.6 to 17.2 per 100,000 of population, age-adjusted. This gratifying decrease in mortality, in the opinion of the Commission, is mainly due to a greater diagnostic alertness by physicians generally, and is evidence of the value of radiotherapy.

REFERENCES

1. Cancer Commission Studies, California Medical Association, J. W. Stacey, Inc., San Francisco, 1936.
2. California Cancer Commission Studies, California Medical Association, 1950.
3. Traut, H. F., and Benson, R. C.: Cancer of the Female Genital Tract, American Cancer Society, Inc., New York, 1954.

CANCER DETECTION

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C. M. A. House of Delegates Proceedings

Los Angeles, May 9-13, 1954

Sunday Morning Session

The Sunday morning session of the House of Delegates of the Eighty-third Annual Session of the California Medical Association was held in the Renaissance Room, Biltmore Hotel, Los Angeles, California, Sunday, May 9, 1954. The meeting was called to order at 9:30 a.m. by the Speaker, Donald A. Charnock, M.D., who presided.

SPEAKER CHARNOCK: Will the House of Delegates of the Eighty-third Annual Session please be in order.

The first order of business is the report of the Credentials Committee.

REPORT OF THE CREDENTIALS COMMITTEE

DR. LOUIS P. ARMANINO: Mr. Speaker, a quorum is present. I move that we accept the visual roll call as evidence of constitution of the House.

SPEAKER CHARNOCK: It has been moved and seconded that we accept the visual roll call as the constitution of the House. Those in favor will signify by saying "aye." To the contrary?

... There being no discussion, the motion was put to a vote and it was unanimously carried. ...

SPEAKER CHARNOCK: The House is constituted. The first order of business that we have today is a very pleasant one. We are going to have the annual report of the Woman's Auxiliary to the California Medical Association presented to this House, I believe, for the first time. It is a great pleasure and privilege at this time to present to the House of Delegates Mrs. Carl Burkland, president of the Woman's Auxiliary to the California Medical Association. Mrs. Burkland! (Applause.)

REPORT OF WOMAN'S AUXILIARY

MRS. CARL BURKLAND: Thank you, Dr. Charnock. Dr. Green, members of the House of Delegates, Auxiliary members and friends:

When the Auxiliary assumes the leadership of any activity, bringing into play its organizational ability, enthusiasm and steadfastness of purpose, there is action; things happen and another successful year results. As your ally, we are grateful for this opportunity to report the salient features of the stewardship you have reposed in us.

All our activities are concentrated in the primary design of furthering the development of a greater recognition, understanding and appreciation of American medicine and the services of our doctors. Much stress is laid on a substantial and healthy growth in membership in order to render this serv-

ice. Although our 5,559 members represent the wives of less than one-half of the physicians in the state, the full program for the Auxiliary is being executed by them. Surely each of the members of this House of Delegates is aware of the grave responsibility we have shouldered, that of making sure everyone, everywhere, is exposed to medicine's point of view. If you will assist us in recruiting the other one-half, knowing that in numbers there is strength, our power of effectiveness will likewise multiply.

Stressing a positive approach to a solution of alleged medical problems, our overall program seeks to educate the doctor's wife and then the lay person. This program was outlined at the state fall conference for all state officers, county presidents and presidents-elect. Workbooks were distributed, containing detailed plans for each committee's work, and after an instructive period a round table discussion followed. Much of the complete cooperation between state and local Auxiliary may be attributed to this session.

1. All but six counties held an open meeting to which representatives of various lay groups were invited as guests. By means of the newspapers the general public was made aware of the program to be presented. The public relations value is obvious.

2. By financial and volunteer service, 72 organizations were assisted; in their state and local branches we have 125 Auxiliary members who occupy positions of leadership.

3. Two Auxiliaries sponsor essay contests of a medical nature, with prizes to high school students in the schools.

4. Sixty thousand nine hundred pamphlets and posters on voluntary health insurance were distributed to physicians' and dentists' offices, drugstores, hospital waiting rooms, and so forth.

5. Four hundred seventy-three gift subscriptions of *Today's Health* were placed in schools, libraries and beauty parlors. Noteworthy of mention are three counties, who contributed this periodical to 86 P.-T.A.'s. However, before we attempt to educate the public as to the value of the authentic health magazine, it is wise to keep in mind that all those serving in the medical field should also realize its potential value and subscribe to it.

6. Booths were manned at six county fairs, where movies on health projects were shown, questions answered and literature distributed to the public.

7. Nurse recruitment, through various modes, continues to be the major interest of all Auxiliaries. This year, through their efforts, 73 applicants have received aid by loans or direct scholarships; seven

Auxiliaries sponsor Future Nurse Clubs; three maintain grants - in - aid for needy student nurses and others contribute gifts directly for the student nurse homes.

8. The mental health program materialized in October. Since it is newly organized, the counties are still in the process of preparing the program and learning community needs.

9. Civil Defense is not a popular subject but we cannot be like the proverbial ostrich and have our heads in the sand, so we persist in alerting our members to its need.

It is interesting to note that under the type of public relations on the county questionnaire, almost everything we did was for others. Our publicity and work are geared to acquaint the public with the fact that the public health is truly our concern.

10. Due to a systematic, energetic and capable historian, a 25-year history of the character and scope of the Auxiliary's achievements throughout the state was published.

11. The American Medical Education Foundation has gained momentum both financially and in understanding of its purpose. This particular phase of Auxiliary activity has commanded special attention and the results are amazing. Gratifying, too, is the perseverance of interest in the Physicians' Benevolence Fund.

The statistics received revealed the following approximate figures for philanthropies:

Community—\$11,637.33.

Nursing field—\$16,422.25.

Physicians' Benevolence—\$3,328.33.

American Medical Education Foundation — \$5,800.60.

In order that the House of Delegates may have some idea of the necessary activity of an Auxiliary president, the following has been compiled: Attendance at national convention in New York; 100 year-books compiled for state and county officers; state fall conference planned and executed; national fall conference attended in Chicago last November; C.M.A. Advisory Board informed of all procedures and directives; articles written for all issues of *Courier*; visited and delivered addresses to 30 county Auxiliaries throughout the state; wrote over 1,500 letters (filing necessary copies for reference) and have striven to prepare the agenda for this convention in such a manner that it is satisfactory to the California Medical Association and creditable to the Auxiliary.

The constant and enthusiastic cooperation of the state and county officers and the individual efforts of "working" members have been responsible for whatever accomplishments the Auxiliary has made, and to each the president expresses sincere appreciation and gratitude. It is an unforgettable privilege to have served as their leader.

To Mr. Hunton and Mr. Thomas and their competent staff, our deep indebtedness for their generous, wholehearted help and advice.

To Dr. John Green, and the Advisory Board, our appreciation for their interest and understanding.

To the California Medical Association, our sincere thanks in continuing to keep *The Courier* the outstanding publication of its kind, through their generosity in underwriting its cost and also in contributing toward the success of the Auxiliary session during this convention. The most prized possession of the Auxiliary is its good will and fellowship, which is the necessary spark for our continuance. On behalf of the Auxiliary members, their president extends to the members of the House of Delegates our greetings with the hope that our world may continue to profit by—and indeed become more united through—our doctors.

Thank you. (Applause.)

SPEAKER CHARNOCK: Thank you very much, Mrs. Burkland. I think it is very significant that we should have represented today, on Mother's Day, the distaff side of the California Medical Association. I think the report shows the magnificent work that these ladies are doing and I think we should all give them a big hand for the continuation of this effort. (Applause.)

At this time we wish to announce the Reference Committees for your approval.

The Credentials Committee, Louis P. Armanino of San Joaquin, R. Wendell Coffelt of Los Angeles and F. P. Wisner of Yuba-Sutter.

Reference Committee No. 1, J. W. Moore of Ventura, Dave Dozier of Sacramento and Thomas Dozier of Alameda-Contra Costa.

Reference Committee No. 2, John E. Vaughan of Kern, Thomas P. Hill of Mendocino and Henry Gibbons III of San Francisco.

Reference Committee No. 3, Carl M. Hadley of San Bernardino, Helen B. Weyrauch of San Francisco and Samuel B. Randall of Santa Cruz.

Reference Committee No. 4, Thomas A. LeValley of Los Angeles, Dorothy M. Allen of Alameda-Contra Costa and James E. Feldmayer of Tulare.

C.P.S. Reference Committee, Paul D. Foster of Los Angeles, Dan O. Kilroy of Sacramento and Fred A. Olson of Humboldt.

Is there any objection from the House to the constitution of these committees? The Chair hearing none, declares them constituted.

Reference Committee No. 1 will meet in Room 1344.

Reference Committee No. 2 will meet in Room 6333.

Reference Committee No. 3 will meet in Room 1223.

Reference Committee No. 4 will meet in Room 1234.

The C.P.S. Reference Committee will meet this afternoon, as will be announced later, in this room and subsequently in Room 1348.

At this time it is a great pleasure and privilege to call upon our President, John W. Green. Dr. Green! (Standing applause.)

ADDRESS

PRESIDENT GREEN: Mr. Speaker, Past Presidents of the Association: I am glad to have you here this morning. Members of the House, ladies and gentlemen, guests:

I have no formal address to make to you. In years past when the president didn't go up and down the state meeting with the county societies he was practically unknown to many members of the House. In these days, recent years, when the President has gone up and down the state he is pretty well known. Not only that, but the members know pretty well what he stands for. I am sure everyone here knows that I stand for good medicine and I should say at this time that the very best thing, the very best policy that you can adopt personally in your offices, is that you seem to be honored by the people who come to you for help in their troubles, and that you be sympathetic with them at all times. Also, that you give to them the very best that you have of your professional experience and skill, and in the giving of this service that you be extremely courteous.

By this they shall judge you. I believe in strict honesty between you and your patient with regard to financial matters and the means that you adapt your practices to them, to take care of their financial obligations to you in the rendering of your service. One other thing that your Past President, Gordon MacLean, asked me to mention some time ago and which I forgot, but seeing him here this morning reminds me of this. He said this: In regard to referrals of patients, all of you know that when you send a patient from your office to a doctor for reference, opinion and so forth, you ask him for a report back to you of his finding and his recommendations. One thing that has caused a little bit of difficulty in recent years is the fact that perhaps a general practitioner in referring a patient to the referral doctor omits much information which he might forward to the doctor and many unnecessary procedures in the way of laboratory investigations and so forth might be omitted; this means doing this a second time and charging the patient the second fee for this.

I call that to your attention because I believe it is quite important. One other thing, I believe every doctor in the State of California who is in practice should be what I term a "Cadillac doctor." I don't mean by that that all doctors should own and drive Cadillacs, but I do believe that they should represent in medicine that same efficiency and reputation for quality the Cadillac has in the automobile field.

I have some other reports to make in the supplementary report which would be repetitious if I said anything about it at this time. So with these few remarks we will proceed with the business of the House. (Applause.)

SPEAKER CHARNOCK: Thank you, President Green.

At this time we have some more duties for our President; he is going to present the Fifty-Year pins and I am going to call up those physicians who are eligible for Fifty-Year Membership pins.

Will these gentlemen, if they are present, please come forward?

From Fresno County, Lamont R. Wilson, George A. Hawkins; from Humboldt County, John M. Chain, from Los Angeles County, Frank S. Dillingham, William R. Molony, Sr., Russ Moore, Reginald S. Petter, Celia Reichi, Eleanor C. Moore and C. W. Yerxa; from Orange County, Herbert A. Johnson; from Placer-Nevada-Sierra County, Robert E. Peers; from Tehama County, Frank Doane.

Will these gentlemen please come forward? Come to the platform.

... Those present came to the platform. ...

PRESIDENT GREEN: Members of the House and friends: It gives me a lot of pleasure this morning to award these Fifty-Year pins for service. It is a little bit unusual for a doctor to be able to continue his exertions in the service of his patients for a term of fifty years. I know how difficult that is because I am approaching that point myself and I believe the last few years must be the hardest. (Laughter.) I am just completing my forty-sixth year. However, not all of that has been in the State of California, but I have been in California for a normal span of years of practice even at that.

So I hope you will join with me in congratulating the four gentlemen we have on the platform this morning in the award of this distinguished honor.

This one goes to Dr. Robert Peers of Colfax. (Applause.)

... The award was presented to Dr. Peers by President Green. ...

PRESIDENT GREEN: As you all know, Robert served us in every capacity possible through the years. He was for a long time perhaps the oldest secretary of the county medical societies in point of years of service. To my knowledge he was chairman of the Secretarial Board when I was a county secretary many years ago.

Robert, my congratulations.

DR. PEERS: Thank you, old dear. (Laughter.)

PRESIDENT GREEN: I hope they wear these pins with as much distinction as they did while earning the honor to wear them.

And now we have Dr. Yerxa, a doctor of distinction also in his community. I do not know the Doctor personally so I can't recite anything personal about him but I do congratulate him on his service to all of us and to all of his patients. Doctor! (Applause.)

... The award was presented to Dr. Yerxa by President Green. ...

PRESIDENT GREEN: And next we have another distinguished doctor from Los Angeles County whom I have no knowledge of, but I still feel that I can congratulate him just as equally as though I do know him. His name is Reginald Petter. In case you might not know what this spells, it spells P-e-t-t-e-r. Dr. Petter, my congratulations. (Applause.)

... The award was presented to Dr. Petter by President Green. ...

PRESIDENT GREEN: And last but not least we have Dr. Russ Moore from Los Angeles County and I should like to say to you gentlemen that I envy this man his goatee. (Laughter.) And his professional appearance, because I have no hair on my head. (Laughter.) Neither do I have any on my chin. (Laughter.) So I congratulate you, Doctor, for your service also. (Applause.)

... The award was presented to Dr. Moore by President Green. ...

PRESIDENT GREEN: And now, Dr. Peers, I believe you would like to say a word, which is certainly right and proper at this time. Dr. Peers!

DR. PEERS: My good friend, John Green, members of the House of Delegates and guests:

This is an unusual type of recognition. You know, ordinarily when one is given recognition in a manner such as this it is because of some work that he has done, some actions on his part. But in order to get this particular recognition, this particular pin, one has to show good judgment in the selection of his ancestors (laughter) so that he has a long life assured him. Another thing, he has to join the organization early in life, pay his dues every year and keep out of the hands of the police and the Board of Medical Examiners. (Laughter.) But seriously, I want to tell you that it has been a wonderful pleasure and a wonderful experience to have been associated with the men and women of this great organization. You have been awfully kind to me. You have given me many honors. I may not be here many times more, and so I wish to tell you what I have told you before, that I appreciate very much all the things you have done for me. I try, of course, to deserve them. I didn't always agree with the boys but I always did my best for organized medicine.

It is a sad thing—there is a sad element here—and that is so many of the good men and women that I have known through the years are not here to receive their Fifty-Year pins. I think particularly at this moment of my good old friend, George Kress, who lived to within just a few months of the date of receiving this recognition.

Now I thank you again and I just have one hope for you and that is that each and every one of you will enjoy the work of this organization as I have done and that the time will come when each and every one of you will come up here and get the Fifty-Year pin. Thank you very much. (Applause.)

PRESIDENT GREEN: As they say in TV, Robert, don't go away, we will be back on the air in a few moments.

This is a Certificate of Merit awarded to Robert E. Peers, M.D., by the California Medical Association for the many years of service as secretary of the Placer-Nevada-Sierra County Medical Society signed by Dr. Green and Dr. Shipman for the Association. Robert, there is something that you can also appreciate for your long service to us, and knowing that we appreciate it.

... The certificate was presented to Dr. Peers by President Green. ...

DR. PEERS: Thank you. It will be on the walls of my office as soon as I get home.

PRESIDENT GREEN: And thank you.

One thing more. It seems as though honors don't come singly to these fellows when they are Fifty-Year pin holders. Here is a telegram that just arrived. It is addressed to Dr. Robert E. Peers, the Biltmore Hotel.

"Congratulations, Dad, on attaining another fifty-year award. Carry on. Love,

"Robert and Betsy."

(Applause.)

The other gentlemen think that Dr. Peers expressed exactly what they feel and they say it would be repetitious should they take any time at this moment.

SPEAKER CHARNOCK: At this time we have another award to make, Dr. Green. We have an award to make to Dr. Arthur E. Smith. Will Dr. Smith come forward?

... Dr. Smith came to the platform. ...

SPEAKER CHARNOCK: Dr. Smith has for many years put on a motion picture program for this Association. He has done a tremendous amount of work and has put on excellent programs. And in recognition of this the California Medical Association is awarding him this certificate.

PRESIDENT GREEN: Dr. Smith, we are very glad to have you with us this morning. This will introduce Dr. Smith. I shall read his award:

"Award of Merit.

"The California Medical Association confers upon Arthur E. Smith, M.D., this Award of Merit for his devoted service for five years as chairman of the Motion Picture Committee."

Signed by Dr. Green and Dr. Shipman. (Applause.)

... The award was presented to Dr. Smith by Dr. Green. ...

PRESIDENT GREEN: Dr. Smith would like to address the House for a moment.

DR. SMITH: President Green and members of the House of Delegates: I deeply appreciate this honor. As Dr. Green stated, I have been honored with the chairmanship of the Motion Picture Division for five years, and believe it or not, five years ago when I was appointed, the Motion Picture Division was small. At the present time it has grown from infancy up to the best-attended section in this meeting. That is by actual count. That has come to me several times from various parties throughout the country that our Motion Picture Exhibition is the largest of any in the United States. I don't deserve all the credit but I wish to state that my very efficient secretary, Miss Jones, deserves as much credit—the unsung individual. For five years we have labored together, and believe it or not, gentlemen, it has taken a lot of time. And the counsel that I received I wish to make mention of because when the rough spots turned up with various films, where we didn't know whether

they were good or bad, didn't know whether to accept them or not, it was through the wise counsel of Louie Alesen, Dr. Baumgartner and Dr. O'Neill, and I wish to make mention also of the wonderful cooperation that I received from the American Medical Association and the American College of Surgeons for the selection of outstanding films.

At this meeting we are screening 97 films covering every branch of surgery so we hope that you will find a little time to drop in and see us. I again thank the House of Delegates and President Green for this wonderful honor and I assure you that I will carry on the best that I can in the future for the betterment of the motion picture exhibition. Thank you. (Applause.)

SPEAKER CHARNOCK: Thank you, Dr. Arthur Smith.

We have one more presentation to make. This is to a young lady. The House of Delegates of the California Medical Association is presenting today a prize of \$500 to Miss Beverly Tarver, a senior at Mayfield School in Pasadena, winner of second honors in a national essay contest on the subject, "How Can We Attain the Best Medical Care?"

Miss Tarver's essay won first prize locally in a contest sponsored for high school students by the American Association of Physicians and Surgeons.

Born and raised in Los Angeles, the daughter of a local Doctor of Dentistry, Miss Tarver will enroll at Stanford University this fall. I am going to have Dr. J. Philip Sampson present Miss Tarver to Dr. Green.

PRESIDENT GREEN: I didn't have any idea that I would have the opportunity to introduce to you, this House, such a lovely young lady. At my age I can appreciate them a little bit more than I could when I was her age. (Laughter.)

It seems particularly fitting, ladies and gentlemen, for me to give this check to this young lady who shows great promise, because I happen to have been a charter member of the American Association of Physicians and Surgeons and have been through the years. So the check that I am about to present to her for them and for you—because I know in this House there are many members—a part of the money that you have paid in dues through the years. Your \$10 that you pay every year does such fine things as this to deserving young men and young ladies if they can possibly win it.

This is a thing that has been going on year after year and we are honored to have one of our own get this award of \$500. I should like to introduce to you now Miss Tarver who may have a word to say.

... The award was presented to Miss Tarver by President Green. ...

(Applause.)

MISS TARVER: All I can say is thank you very much and I am very proud and very pleased to receive this award. Thank you. (Applause.)

SPEAKER CHARNOCK: Thank you very much, Dr. Green, for all those duties you have performed.

There are one or two announcements that we wish to make. First of all, stenographic services are available in the C.M.A. office in Room 1221. Anything that you want in the shape of resolutions typed up or some little letters back to your friends, just go up to C.M.A. office and I am sure they will type them up.

At this time we would like to welcome the press, which is with us today. We hope that they get a lot out of this meeting.

One other announcement which we have to make and that is that this apparatus that sits in front of you and over toward my right is a television apparatus of which I understand nothing, but I do understand that it is hot and if anybody touches it they will be immediately electrocuted. (Laughter.) I can think of some people whom I would invite to touch it but for the general members of the House we do not want to reconstitute the House so please, delegates and members of the House, do not touch it. (Laughter.)

There will be county caucuses for the three Councilor Districts which are nominating Councilors at this session. The Third District is the Los Angeles District. They will meet in the Los Angeles Room at 5:00 o'clock today. I will have the number of that room for you before this session is over. I have it here, Room 7334, the Los Angeles Room, at 5:00 p.m. today.

District No. 6, Fresno County, and the other, and Tulare County, Monday at 1:00 p.m., Room 6229.

The Ninth District, Alameda and Contra Costa Counties, today at 12:15, Room 8333. Please be advised of these caucuses.

At this time the Eleventh District wishes to caucus today at 5:00 o'clock in Room 9303.

DR. RIXFORD: Mr. Speaker, I would like to make an announcement to the San Francisco delegation.

SPEAKER CHARNOCK: You would like to have a caucus?

DR. RIXFORD: Immediately following this morning session in Room 1223 there will be a brief caucus of the San Francisco delegation. Thank you.

SPEAKER CHARNOCK: All the Districts will please take notice.

At this time we are going to have our supplementary reports. We have tried to have the report in the Convention Bulletin be the full report but there will be some supplemental reports made. And at this time we will call upon Item 21, the report of C.P.S. Board of Trustees. Dr. Hodges.

REPORT OF C.P.S. BOARD OF TRUSTEES

DR. FRANCIS T. HODGES: Mr. Speaker, Delegates: The California Medical Association in February, 1939, proudly presented for approval its new child, the California Physicians' Service.

Like all infants, it was coddled, spoon-fed and supported by its parents who like all parents expected much of it. It experienced normal growth, outgrew its cradle clothes, behaved like most lusty youngsters, and often exhibited a mind of its own.

For yet in Sunday clothes and when posing for its portrait it did credit to its progenitors and received many a pat on the head.

Even when its distressed parents in punishment for recalcitrant behavior occasionally warmed its backside, it still was assured it was a loved member of the family. Oh, it may have threatened to run away from home a time or two, and I seem to remember sometimes when its parents contemplated running away from it, but the child grew and finally matured, even became self-supporting.

Adolescence evoked the usual bewilderment with awkwardness and strange ways. Illnesses furrowed parental brows while the child lost weight, but they were not critical illnesses. The nurses, the pediatricians and the tutors did their best and the family may now take some satisfaction in seeing its child at work. It can rightfully be expected to work for those who produced it and this is its work progress report.

In March of 1953 C.P.S.-Blue Shield designed a program intended to accomplish the following ends:

1. The development of simpler and better contracts suited to the needs of subscribers, employers and others responsible for payment of premiums and satisfaction to the physicians and hospitals rendering the services contracted for.

2. A reversal of the downward trends in membership and a healthy regrowth.

3. Unceasing attention to financial soundness, a prime essential to the interests of physicians and subscribers.

4. Adherence to the principle that satisfactory public and professional relations are the product of operations that win confidence rather than of some department or agency for this purpose.

5. Sound and efficient administration to make the operating costs a much smaller and smaller percentage of gross income, thereby permitting increasing benefits to the public and more adequate reserves and ample fees to doctors.

New contracts. Exhaustive study by many C.P.S. administrative members and the Contract Committee under Dr. Reynolds has led to the new type of group contract now to be offered to the public. These contracts not only are simplified as suggested by the C.P.S. Study Committee but benefits have been broken down, many annoying exclusions, exceptions and limitations have been abolished and overlapping eliminated. Rates are established that are adjusted to current trends. Intended to parallel the new group contracts in their far more realistic features are new direct pay and individual contracts now being perfected, providing for continuation of broader benefits to the subscriber leaving a group and also permitting coverage beyond the usual retirement age. Through this agency at least a partial solution to the ever greater problem of medical care for the aged may be found, and without any great change in C.P.S. policy.

Current study also concerns other aspects of financing illness costs of the elderly as well as of the indigent in certain areas lacking public facilities for the purpose. Some statisticians point out that this branded type of care can be more economical to the community. Certain college groups also will have coverage based upon their specific needs. There is also current examination by the Contract Committee of coverage of the so-called catastrophic illnesses, with the intent of offering more realistic protection. No half-baked or prematurely conceived contracts will be offered by C.P.S.

Membership—Subscriber Members. It is not necessary to repeat the sequence of events that led to the diminution of subscriber membership from the high of 1,029,048 in December of 1950, when there was joint operation with Blue Cross, to the low of 599,279 in July of 1953, when dissolution of this relationship was about completed. A profound change in sales methods was inaugurated at about that time. A factual, low-pressure type of approach. Jalopy-lot pitches have no place in C.P.S. promotion. The steady growth to 630,982 at the end of March 1954 attests to this less dramatic but more ethical approach. We conservatively estimate that the end of next March will see an additional 95,000 added to our rolls, a total of 727,244, without any change in income ceiling or similar stimulant.

There is beginning to be a demand by labor and national businesses for an organization that can underwrite interstate sickness protection despite the obvious present absence of facilities. Certain closed panel plans desire this business; up to now they cannot furnish the required service. Only Blue Shield and Blue Cross currently can. We should show aggressiveness in retaining for private medicine the increasingly greater number of workers available for coverage.

C.P.S. has been alert and active. Recently 8,000 members have so been added to our rolls, the largest such contract being with Swift & Company. Certain West Coast industries also are being written through mutual contracts with plants in neighboring states. We can reasonably expect C.P.S.-Blue Shield, within the limits set forth by the medical profession, to grow. The groups now being enrolled, while small, are composed of those people who most appreciate the services of a doctor known to them, and who value the freedom to choose whom they desire.

Physician Members. A net of 391 physician members were added to our list during the fiscal year just completed, bringing our membership to an all-time high of 11,485. In the fall of 1953 a number of resignations were received from internists. Precipitating this action was a resolution adopted by the California Society of Internal Medicine relative to the long existent problem of whether C.P.S. should recognize a differential fee schedule for internists. Because of the great need for unity within the profession in the interests of the best public relations it is hoped that this problem can be resolved. Let it here be mentioned that many internists withheld

action or cancelled their resignations with this most vital thought in mind.

Meeting Closed Panel Competition. The C.P.S. Study Committee, in reporting to the House of Delegates, urged county societies to devise plans that could compete with closed panel plans. Success was predicated upon the following:

1. A high degree of doctor confidence within the unit.
2. Management sponsorship or approval.
3. Group sponsorship by union labor or other organized group leaders.
4. Contracts with comparable benefits, rates that are in relationship to services offered and a realistic consideration of the matter of income.

The four conditions vary relatively with the situation but all must be present if physicians and Blue Shield are to achieve success. An outstanding instance of such success is the new contract signed by C.P.S. with the new branch of the University of California in Riverside at the request and with the cooperation of the local doctors. A closed panel plan was thus rejected.

San Pedro's spectacular success was even more noticeable. There with Dr. Horn's able leadership the physicians brought about a cooperative action with labor and management that led to the enrollment of 4,000 subscribers. A key factor in this success was the voluntary action by the local physicians in waiving the income ceiling cost, thus accepting C.P.S. fees as full payment. Dr. Horn will tell you that this feature rendered C.P.S.-Blue Shield's contract competitive. It is also noteworthy that this community has felt a high doctor confidence from the very start.

C.P.S. Income Ceiling. Consideration of the income of the individual patient as one criterion for the setting of the doctor's fee is traditional in the medical profession. Today union labor leaders bargain with management for so many cents per hour, regardless of the income of the individual employee, to cover the cost of medical-surgical and hospital care as a common practice and labor negotiators claim it is most difficult to explain to their union members why doctors' fees should vary when the contribution of the employer is on a flat hourly basis. In fact, many labor negotiators speak often contemptuously of medicine's Robin Hood method of fee setting. Most labor leaders will not attempt to explain this difference to union members, with the result that C.P.S.-Blue Shield sells few large groups. Where doctors have been active in the solicitation of any large group in competition with closed panel plans, that is without an income ceiling, they have been continuously reminded by group leaders that the income ceiling must be raised to \$6,000 or eliminated.

In both Riverside County and San Pedro the income ceiling was eliminated in order that the groups involved might be retained for doctors in the private practice of medicine.

During the past few months there has been increased activity on the part of different groups within the medical profession to secure an increase in the C.P.S. annual income ceiling.

The C.P.S. Board of Trustees and management followed a policy of selling contracts within the present limitations, feeling that it was the decision of the medical profession and not that of C.P.S. to make possible the enrolling of larger groups through the raising of the income ceiling if the profession desired to do so. C.P.S.-Blue Shield stands ready to continue its cooperation with any county society or any group within the profession, but the officers, trustees and management feel that the income ceiling decision is one for the profession and the profession only.

The Financial Status of C.P.S.-Blue Shield. C.P.S. continues in a sound financial position. It is believed that reserves are adequate to meet any normal contingency, the total being midway between the minimum and maximum recommended by the National Association of Insurance Commissioners. The Financial Committee of C.P.S. and the management have given consideration to the possible adverse effect on the financial condition of C.P.S. in the event of increasing unemployment. The effect of growing unemployment in the Middle West on Blue Shield plans is being watched and it is believed that the finances of C.P.S. can be so handled as to meet any increased unemployment in this state without materially affecting the soundness of the operation.

Through more effective control of costs and adequate budgeting of expense it was possible to increase the fees paid to doctors on January 1, 1954. It is anticipated that the added payments will total approximately \$1,400,000 in the twelve-month period.

During the period from 1949 to date C.P.S. has increased its payments to doctors from 80 to 90 per cent of the existing schedule, from 90 to 100 per cent and from 100 to 107 per cent of the C.P.S. Schedule of Fees.

This most recent increase in the payment of fees has been accomplished without an increase in the rates charged subscriber members and it is hoped that continued growth and efficient operation will permit additional readjustments as income warrants.

Fee Relativity. The value of one fee as compared with another is receiving wide study by many groups across the country and may lead eventually to a more universal fairness of fees.

C.P.S. - Blue Shield - Blue Cross Affiliation. The C.P.S. Study Committee recommended a closer affiliation between the two Blue Cross plans in California and C.P.S.-Blue Shield. The benefits of such association in other areas of the country are impressive. Much larger operations than ours work in harmony. While it was not practical or possible to stop the dissolution or the joint operation of Blue Cross and Blue Shield in Southern California, groundwork was laid for cooperative effort in the solicitation and servicing of national accounts. This

joint handling of national business has made possible the closer and more friendly relationship resulting in the elimination of unethical competition between the three non-profit plans. Meetings of the joint Blue Cross-Blue Shield Committee under the leadership of Dr. Lewis Alesen—and there was one last May in this hotel—are meetings held as occasions warrant, and it is hoped that an even closer affiliation may ultimately result. Consummation can be achieved by realization by all parties of the vital interests of each, but even more so by consideration of the public good. Possibly one way that we can work to achieve this is the joint writing of certain contracts which may be a triumph of this aim that we hope to achieve.

The Veterans' Program. The program of home town care for the veterans of California continues in the same pattern as during the previous year. In the past twelve months the doctors of California were paid through C.P.S.-Blue Shield a total of \$1,573,030.72. During the past year the Veterans Administration has been subjected to pressure for the reduction of expense and this cost reduction program has reduced the total funds available for the Veterans' Program in California. Due to the size of the state and the inadequacy of veterans' hospitals and clinics it is believed that this program can continue and thus preserve for the doctors of the state the opportunity to serve veterans in all areas where no veteran facilities now exist.

Relations with Other Blue Shield Plans. During the past year much progress has been made in broadening and cementing relationships with other Blue Shield plans in various sections of the country. The Blue Shield community is of increasing importance nationally. Your president has been invited to address doctors in a number of states on the Pacific Coast on problems of mutual interest, with the result that the problems of C.P.S. and its present objective are more sympathetically understood.

An active part has been taken by your president and your past president, Dr. Cass, and members of C.P.S. management in National Blue Shield Commission programs. Meetings have been attended in Chicago, New York, Pittsburgh and elsewhere. A demonstration of the willingness of other Blue Shield plans to work with C.P.S. in the development of national business has been reassuring. It is anticipated that a closer working arrangement will make possible the securing of a greater number of members among people moving to California.

Through the election of the Board of Trustees C.P.S. is now cooperating in the financing of an advertising campaign for Blue Shield in national magazines, and the effect of this advertising in making C.P.S.-Blue Shield better known among management, labor and other groups is already noted. This advertising is carefully planned to be coordinated with the advertising programs normally conducted by the various Blue Shield plans.

Today's Attitude of Doctors Toward C.P.S. The active and enthusiastic cooperation of doctors from

Oregon to the Mexican border has not only been reassuring but inspiring. In areas confronted with active closed panel plans the doctors have given of their time and effort to meet with management, labor leaders and others in a sincere effort to evolve a program that would continue to permit the free choice of physician and at the same time give the subscriber member a good and sound plan of providing funds for the payment of medical, surgical and hospital bills when necessary.

The C.P.S. decentralized program, first tried on an experimental basis in Santa Clara County, is now being extended throughout the state. Most counties had active C.P.S. Contract Committees and these committees are working not only in their own societies but are reviewing unusual claims, suggesting prospects for the sale of C.P.S. contracts and actually cooperating in the sale of contracts to larger groups.

There has been a marked increase in the support of doctors in all types of programs for the providing of funds for the payment of medical, surgical and hospital bills, resulting in more helpful advice to patients and closer working arrangements with their own societies and carriers of health insurance including C.P.S.-Blue Shield.

Indemnity Type Insurance. Following the adoption of a resolution by this House of Delegates and approved by the C.M.A. Council and the C.P.S. Board of Trustees, the California Physicians Insurance Corporation was formed. The various requirements of the office of the Insurance Commissioner, because now we are dealing with insurance and we deal with the Insurance Commissioner as far as this is concerned, have been met, \$400,000 has been invested by C.P.S. in this insurance company and it is anticipated that the final approval needed from the Insurance Commissioner will be forthcoming in the very near future.

This insurance company has been formed as a non-profit corporation with all of the shares of stock owned by California Physicians' Service and it therefore is a wholly owned subsidiary.

It is anticipated that contracts on an indemnity basis, covering employees of national corporations will be written in the not too distant future. The insurance company will be prepared to develop and write policies of insurance on an indemnity basis using the average fee schedule plan in such areas as requested.

As the members of the House of Delegates know, a number of counties have now developed their own fee schedules but as yet no request has been made by a county actually to sell insurance using any of these fee schedules.

While originally conceived for the purpose of writing this type of coverage within the state, this company is additionally useful because of the new interstate contracts. Many of the technical problems developing may be more easily solved as a result. The trustees and the administration were greatly heartened by your acceptance of the C.P.S. report at the December Interim Meeting. The efforts of all will

constantly be exerted to keep C.P.S.-Blue Shield an effective public trust because that is what it is.

If I may return to my metaphor and torture it a bit in terminating—after all his years of being supported by his parents, our child appears now to be physically able to help them and shows fair promise of being recognized by the neighbors as a responsible and useful citizen who can defend his own home and the entire community of which he is a part. Thank you. (Applause.)

SPEAKER CHARNOCK: Thank you very much, Dr. Hodges. This report will be referred to the C.P.S. Reference Committee.

At this time we are going to have the Past Presidents of this Association stand up. Those who are present at the meeting, will you please stand; we are going to have Dr. Molony, who has just recently come, come up and get his Fifty-Year pin.

Dr. Ewer, Dr. Kinney, will you please remain standing? Dr. Junius B. Harris, Dr. Reinle, Dr. Peers, Dr. Harry Wilson, Dr. Molony, step up on the platform. Dr. Karl Schaupp, Dr. Lowell Goin, Dr. Sam McClendon, Dr. John Wesley Cline, Dr. E. Vincent Askey, Dr. R. Stanley Kneeshaw, Dr. Donald Cass, Dr. H. Gordon MacLean, Dr. Lewis Alesan.

Will you gentlemen please remain standing while Dr. Molony receives his Fifty-Year pin?

PRESIDENT GREEN: Members of the House: It gives me a lot of pleasure to present this pin to my old friend, Bill Molony, whom I have known for many years and very favorably. My congratulations to you, Bill.

... The award was presented to Dr. Molony by President Green. ...

DR. MOLONY: Thank you.

PRESIDENT GREEN: Would you say a word?

DR. MOLONY: I will say this, that I am deeply honored and very thankful to receive this pin. It is very easy to look backward. Looking backward really doesn't accomplish very much but I always bear in mind what Bishop Conaty of Los Angeles said many years ago: "Don't be looking backward, but keep your eyes on the brow of the hill."

Thank you very much. (Applause.)

SPEAKER CHARNOCK: Thank you, Dr. Molony. Thank you, gentlemen.

At this time we will have an additional report by our President, Dr. John Green.

REPORT OF THE PRESIDENT

DR. JOHN W. GREEN: Mr. Speaker, members of the House: My preliminary report is in print as you well know, delineating my official visits up to the first of January, 1954. I would be remiss if I did not mention the fact that I have also made some other official visits which I will now report as the supplementary part of my preliminary report.

Since the preliminary report already published in *CALIFORNIA MEDICINE* I have attended all meetings of the Council and all meetings of the Executive Committee of the Council in 1954. Visits have also

been made to Riverside County at Riverside and to four branches of the Los Angeles County Medical Association. By special invitation I was a guest of the Sonoma County Medical Society. Tulare County Medical Society was visited in January, and I attended the luncheon meeting for Dr. Edward McCormick, president of the American Medical Association, in San Francisco on January 27.

San Bernardino County was visited on February 1, and on February 16, Bakersfield. On February 20 I attended the annual meeting of the California Blood Bank Commission at Sacramento. This meeting, conducted by Dr. John Upton, chairman, was of particular interest in that it reflected continued activity in all the problems of blood collecting and distribution plus the research effort required. It is not possible to commend this group too much. Their contribution in case of attack which we could face would be invaluable. I call your special attention to the report of Dr. Upton and his commission.

On November 30, by special invitation from Dr. M. D. Wilcutts, Medical Director of San Quentin Prison, I inspected the entire facilities and prison hospital and found the staff well organized and the hospital departmentalized and all activities properly reported. I was agreeably surprised at the cleanliness and neatness of the entire installation. The x-ray and laboratory equipment are excellent and the teamwork of the group was noted. The corps of consulting doctors represents the best in the Bay District. After lunch with the Medical Officer and the Warden, H. O. Teets, we discussed the medical and hospital service at length. Dr. Wilcutts, who was formerly an admiral and commanding officer of the Naval Hospital at Bethesda, Maryland, is to be congratulated on the excellence of the service and his organization. It is not the prerogative of your president to set policy for this organization but I feel it could be a matter of discussion as to the possible merit of a plan to have the Governor of the State of California invite the President of the C.M.A. to make an annual inspection of the prison's facility. I hope this House may decide on this matter. An annual report to the Governor of the State would be gratifying to him as well as valuable to us.

On April 10 and 11 the meeting of the Medical Services Commission was attended and I wish to comment most favorably upon the activities of this group chairmanned by Dr. Magoon, with Dr. Teall as vice-chairman. Their report to the House should be the most interesting and most valuable portion of the present meeting. Give this group a worthy proportion of your praise for the time and efforts by them.

Dr. Francis Cox and his committee have labored long to obtain a new schedule of fees for industrial accidents. A set of circumstances over which they have had no control has prevented up to now the consummation of his efforts. Pay attention to his report.

Dr. Henry Randel has just recently been cited by the Council of Parent-Teachers of California for the work of the Rural Health Committee. The effect of all

the activities is hard to evaluate. One of the members of the committee was kind enough to go to San Francisco and accept the award. This gentleman, Dr. Carroll B. Andrews of Sonoma County, has long been active in this field. Dr. Randel was in Europe at the time of the meeting.

There are many other opportunities for your president to indulge in social activities but the need to practice medicine a little prevented me from accepting many gracious invitations. A president of this Association could very well be a full time man.

Thank you very much. Respectfully submitted.
(Applause.)

SPEAKER CHARNOCK: Thank you very much, Dr. Green. It looks as if the gentleman from Vallejo was really busy.

At this time we will call upon any officers who wish to make supplemental reports, not the standing committees.

... There was no response. ...

SPEAKER CHARNOCK: At this time the Committee on Postgraduate Activities, Edward C. Rosenow, Jr., chairman, will make a supplemental report. The report of Dr. Green will be referred to Reference Committee No. 1. Dr. Rosenow!

REPORT OF THE POSTGRADUATE COMMITTEE

DR. EDWARD C. ROSENOW, JR.: Mr. Speaker: Thank you very much for your generosity in giving me a few minutes to make a supplemental report.

This is a report from your State Postgraduate Committee. On page 24 of your leaflet you will find the complete report and I only wanted to make this additional report.

With the development of the lecture library of Audio-Digest the Postgraduate Committee has made available all of the lecture tapes in the Audio-Digest library for use at any county medical society meetings in the State of California free of charge. You may get these tapes by communicating directly with Audio-Digest at 800 North Glendale Avenue in Glendale, or communicating with the State Medical Offices, 450 Sutter Street, or to Dr. C. A. Broaddus in Stockton, at 1036 North Center Street.

At this time also I would like to make a very brief report on Audio-Digest if the public relations men will distribute these bits of information so that you may have them. These are just some things that you can read at your leisure. We should actually give you each a tape so that you could listen to this instead of reading it, but the conversion of people's education from reading to hearing is a little slower than this and so for at least this meeting we will let you read this as well as listen.

In December this House of Delegates took over Audio-Digest as a non-profit corporation which is a subsidiary of the California Medical Association and your Council advanced the Audio-Digest Foundation \$10,000 to get it started in business. We had 100 subscribers to the digest, which as you know runs an hour. They are abstracts of medical literature and put on tape. At present there are approxi-

mately 600 subscribers. This includes all of those who will subscribe to the weekly digest on general practice, the twice-monthly digest on surgery, twice-monthly on internal medicine and twice-monthly on obstetrics and gynecology.

The amount of money that we have now used from this \$10,000, I am happy to report, is only \$5,000, and I think before another year rolls around we will actually be making a surplus. We don't call it a profit, naturally, but a surplus. Any that we have will be devoted to medical education in the medical schools, as you all know.

We have almost 600 subscribers. Plans are now on foot for expanding the digests in the near future by adding perhaps a digest on pediatrics; after that we will have to kind of see. I want to give also a few little interesting highlights about the digest. We are attempting to set up at the Los Angeles General Hospital a pilot plan in intern and resident training in which we are going to make available to the interns and residents a tape recorder or some method of listening to these and provide them with the lectures and the digest to see whether this is a useful adjunct to intern-resident training.

You might be interested to know that the Standard Oil Company has purchased \$600 worth of supplies from Audio-Digest for distribution to their doctors in Iran. They have 45 doctors over there who have no opportunity to go to meetings for three years. The Interior Department has written us asking for information so that we may send these digests to the doctors in the Indian Service. South America is—I use this as sort of a general term but we have had quite a few requests from South American countries about translating these digests and distributing them in South America. So far we haven't been able to cut through—although we are experts in tape production we are not experts yet in tape cutting, and we haven't got the State Department and a few other little odds and ends in the red tape field handled. We are pretty good at magnetic tape. (Laughter.)

You might also be interested to know that the Postgraduate Committee of the Texas Medical Association wants to use our service as its postgraduate educational program throughout the State of Texas. Organizations such as the American Heart Association have expressed a willingness to make available to us tape recordings of some of their panel discussions, and we have other societies very anxiously cooperating with us in this endeavor. Sometimes men write in and say that the tapes are kind of expensive. They are \$2.75 apiece. If you go to a music store, which I did recently, they are \$3.50 retail and we give you the digest on them. They can be erased and used over. One of my friends said, "You ought to charge a little bit less for having to erase what you have put on there," but (laughter) that is about all that I want to say. The information is all in your report here.

I want though at this time to tell the House of Delegates that I personally have had a great deal of pleasure in working on this project. I think it has a great future and I hope that I may have the privi-

lege of continuing to work. There is one final statement and that is that we have a booth right at the corner of the Galeria where you turn down to the right. I hope all of you or as many of you as can will stop and listen to the Digest. It is possible you have some teenage daughters or somebody at home that would like to begin spinning tape to record the Hit Parade and you might subscribe to one of these digests as a cheap way of getting tape for the teenagers; that will make your product take on added luster.

Inasmuch as we are in the abstracting service, I could make this go on for two or three hours but we pride ourselves on making it short and I thank you for your forbearance. Thank you very much. (Applause.)

SPEAKER CHARNOCK: Thank you very much, Doctor. And now the abstract of the abstract report (laughter) will be referred to Reference Committee No. 1.

We will now have a report on Public Policy and Legislation. Dwight H. Murray, Chairman. (Applause.)

REPORT ON PUBLIC POLICY AND LEGISLATION

DR. DWIGHT H. MURRAY: Mr. Speaker, President Green, members of the House of Delegates: I am glad to be here this morning. The report that we have to give you is a little bit diversified inasmuch as we wish to cover the activities in California as well as something of the happenings in Washington. You may be interested in all these things and I would like for a minute for you to realize who your Legislative Committee is. If Dan Kilroy and Jim Doyle will stand—there is Jim Doyle in the back of the room (applause) and Dan Kilroy from Sacramento. (Applause.)

Now the Advisory Committee is Frank MacDonald. Is Frank here? There is our Surgeon General, Frank MacDonald. We have Dr. Madeley and Dr. Stegemen—are they here? And Dr. Curtis. Is Dr. Curtis here? Dr. Glenn Curtis. Well, they make up the Advisory Committee for the Legislative Committee.

Then on the Washington front we have the West Coast representative as you all know, Dr. Lafe Ludwig. (Applause.) I wanted you to see and know who the members of your committee are. If things go well, compliment the members of the committee. If they don't go well, give the chairman the devil. (Laughter.)

I would like to start off by calling on Ben Read to give a little review, may we?

SPEAKER CHARNOCK: If there is no objection we will have Ben Read make his little report.

REPORT OF THE ADVISORY COMMITTEE

MR. BEN READ: Mr. Speaker, Mr. President, members of the House of Delegates: As you all know, June 8 is the primary election date in California. We assume and hope that you are all registered and

ready to vote, you and the members of your family and acquaintances, your employees. At this time you will select a nominee for United States Senator, all thirty of the Congressional seats from California, Governor, Lieutenant Governor, all of the state officers, twenty State Senators and all 80 members of the Assembly.

Nineteen members of the State Legislature have no opposition. In some of your districts there are some very warm contests. Many of your proven friends are running for reelection and they are going to need your support and assistance. You no doubt have already received information about a number of these; without being specific as to those men, I would just like to mention one instance particularly. In San Diego County, there is your good friend Senator Fred Kraft who stood up when the battle was tough—he kept the compulsory health insurance bills wound up in committee. This is a real fight.

I mention this by way of observing what can be done. A strong medical-dental committee has been formed there and with the aid of other members of the profession, the allied groups and the Woman's Auxiliary, they are doing their best to return Senator Kraft.

We assume that all of you do know who your legislators are. In some cases there is not an incumbent—where there is an incumbent, of course you have his record; you know what he has done. In cases where there is no incumbent, it is an open district with new candidates and we hope you will screen those, get acquainted with them and present to them your views regarding public health legislation and legislation to uphold our professional standards. At this election in June you will select the men who are going to vote upon the laws that permit you to continue to practice as you do at the present time; we ask you to do this. Thank you. (Applause.)

DR. MURRAY: I would like to reemphasize what Ben has said: Now is the time to become acquainted with the people who may represent us in Congress or our State Legislature.

Now, during the past few months the Interim Committees have been studying some problems pertaining to medicine. The committee from the Committee on Public Health in the Assembly and also the Committee on Business and Professions have been meeting, studying some of the problems of medicine. Those committee hearings have been ended and have been taken care of; proper testimony has been given by Dr. Dan Kilroy. He tells me that there is very little to report at the present time, inasmuch as the reports are not finished. The final reports will be ready at the next meeting of the House of Delegates. I don't mean one day after tomorrow, but at the next time the House of Delegates convenes in its next session.

Now on the national front you are probably somewhat interested in what is going on. If you are not, you should be. I will have to say that so far as some of our bills are concerned we are meeting with heavy weather before our national congress. I wish to state

it now so that you may all have clearly in mind exactly what happens before testimony is given for or against these bills. I hear so often that, well, that is somebody going off the deep end. That is not true.

Before a bill is considered by the American Medical Association it is studied first by the West Coast representative here, who represents Oregon, Washington, California, Idaho, Nevada, Alaska and the Hawaiian Islands. That is Lafe Ludwig, whom you saw a few moments ago. Now, this Legislative Committee goes over all these bills line by line. They spend hours and hours studying the bills for what effect they may have upon medicine now or in the future.

After they have gone over these bills they make recommendations to the Board of Trustees. The Board of Trustees then goes over them in the same manner, oftentimes in conference with at least the chairman of the Legislative Committee and finally arrives at a decision whether a bill should be supported or opposed. After that is done, if we will suppose that we are going to support the bill, then the testimony has to be written.

As you know, 75 copies have to be prepared and given to the committee before we can appear. That work is done in the headquarters in which all the members of the staff participate in working out the testimony to be given on these bills. That sometimes is a very long arduous task. When the final report comes out, that is checked again.

We feel that any time a bill is worth while appearing for, it should bring in somebody in an official position for A.M.A.; if he does not give the testimony, at least he is there to give it official status, and that is done.

Most of the time it has been some member of the Board of Trustees who has represented the American Medical Association at these hearings, and I must say that the hearings have been very carefully and well covered. Our legislative officer in Washington works with the Legislative Committee and is constantly in contact with headquarters of the A.M.A. and the members of the Board of Trustees in informing them of any recent or last-minute changes.

Now, gentlemen, I am sorry to report to you that on some of our bills we are having a little heavy weather, as I say, and I might just mention two or three of them. The President's Reinsurance Bill is one. The bill proposed currently is H.R. 2700, the bill that is proposed by Wolverton, the chairman of the Committee of Interstate and Foreign Commerce. There is also the bill for the extension of the Hill-Burton Act, which would visualize additional money to make possible the building or the erection of facilities for treatment and diagnostic centers.

Now that is pretty loosely drawn and isn't very clear, and we feel that that is not probably exactly as we would like to have it. In a few minutes these bills will be a little more carefully explained by our Legal Counsel.

I wish to say this in regard to the entire overall situation in Washington and what we think of it: It isn't very difficult apparently for the Administra-

tion to change, in the various departments, the number one man. That man has been appointed—had been appointed before so it is just a reappointment. But the career men who have established themselves in the number two, number three, number four and number five positions way on down the line, they are the ones that we have to deal with.

I know in one of the departments, the head of the department said to us very frankly, "I know practically nothing about the problems that you are discussing." Therefore these people had to have some advice, so the natural thing is that they take advice from the people who have been there. I understand these career people have been there a long time and they have been working on these problems and their advice is not always parallel with the advice that we might give.

That is where apparently our big difficulty comes in. I don't know what the correction is going to be for it, but at least it is going to take some little time before such things can be corrected. We hope that before we are finished with this session of Congress, things will come out very well.

Practically all of our bills have passed the hearing stage and they are now before the two bodies, either the Senate or the Congress, on the floor for debate.

We have one bill that was introduced just a few days ago that will be of very great importance to the medical profession. It is Senate Bill 3363, Senator Saltonstall; this is the President's idea of the medical care of the military, the dependents of military personnel. That is the bill we have been waiting for for some time and it was just introduced. I got it by airmail yesterday. That bill will have to be—I can't discuss it with you now because I haven't had time to read it and study it, but that will be one of the bills which you will be hearing about before very long.

It is a pleasure to be here, gentlemen. I wish that I could tell you that everything was entirely lovely and all right, but I feel that I must report it to you as I see it, give you honestly and directly our interpretation of the situation.

I think perhaps our legal advisor will discuss the bills briefly with you, the ones about which we are particularly anxious. I wish to say in conclusion that we as usual appreciate all the good work that has been done by the men out on the front as you men are. I have said before many times, and I wish to reemphasize, that it is very heartening and the only thing that makes possible doing such work as this is the cooperation that we get from the members of our own profession. Believe me, it is heartening when you come to our assistance at any time we call for it. And I wish to state to you that when that condition ceases to exist, gentlemen, your Legislative Committee will not be able to function. Thank you very much. (Applause.)

SPEAKER CHARNOCK: Thank you very much, Dr. Murray.

Mr. Hassard will please follow with his report. Mr. Hassard!

REPORT OF LEGAL COUNSEL

MR. HASSARD (Peart, Baraty & Hassard): Mr. Speaker, members of the House of Delegates: I will summarize for you, in quite brief digest fashion, two of the bills that are now pending before Congress which have a direct bearing on the possible future pattern both for the practice of medicine and the operation of hospitals. The first one is the bill to extend the present Hill-Burton law, which provides Federal financing for the construction of hospitals and related facilities. The bill is H.R. 8149. It provides for the extension of Hill-Burton financial aid to hospitals for the chronically ill, for rehabilitation facilities and for nursing homes. So far so good.

Those provisions that I have just mentioned have received and have the support of both medicine, hospitals and other interested groups. In addition, however, H.R. 8149 contains a fourth classification that is defined in the title simply as "diagnostic or treatment centers." The bill contains the provision that for its first year, which would be 1955, the sum of \$20 million is appropriated as grants for the construction in various parts of the country of diagnostic or treatment centers. I wish to point out that under the Hill-Burton law and this extension, the appropriations are annual affairs. It is not just a \$20 million appropriation; it is a continuing year by year appropriation. The Congress can later change, up or down, but seldom does.

The bill defines a diagnostic or treatment center as follows: "The term 'diagnostic or treatment center' means a facility for the diagnosis or treatment, or both, of ambulatory patients (1) which is operated in connection with a hospital or (2) in which patient care is under the professional supervision of persons licensed to practice medicine in the state." That ends my quotation.

Further the bill sayeth not.

Under its terms it is clear that the final determination, if it becomes law, not only of what is a diagnostic or treatment center, who may own same, what practices may go on, and the nature of the care, but the whole gamut of their operations will be left up to administrative discretion and determination in the Department of Health, Education and Welfare in Washington.

The second bill is authored by Representative Wolverton of New Jersey, who holds the extremely important position in so far as medicine is concerned of chairman of the House Committee on Interstate and Foreign Commerce. Now strangely as it may sound, legislation affecting public health in the House of Representatives goes to the House Committee on Interstate and Foreign Commerce, the reason for that being that the power of the Federal Government to regulate and to legislate in the field of medical services or hospitalization stems from the commerce clause of the Constitution.

Mr. Wolverton's bill is H.R. 7700. It provides for the insurance by the Federal Government of mortgages issued by banks or insurance companies for

the purpose of financing the cost of construction of hospitals and medical facilities if such hospitals or medical facilities are used in connection with voluntary prepayment health plans. It provides the extremely modest sum of \$1 billion as the authorized amount of mortgage insurance. Hence, \$1 billion under it could be owed to banks or insurance companies and the credit of the United States of America would be extended to those lending agencies to make certain that they would be repaid with interest at 6 per cent no matter what happened in the future in the operation of the hospital or clinic.

The bill defines a "voluntary prepayment plan" as one in which a group of physicians operates a group practice in conjunction with a clinic or hospital and under which the group sells to the public prepaid medical care and prepaid hospital care obtainable through the physicians employed by the group and through the hospital facilities so constructed.

As the bill is drafted, none of the voluntary health insurers in this country that operate on a free choice basis—by that I mean all of the commercial insurance carriers, all Blue Cross plans, all Blue Shield plans—none of them could qualify because they do not restrict the right of their policyholders or subscribers to the receipt of medical care from a particular group or their hospitalization from a particular hospital.

I think it is evident from that very boiled-down summary of the bill that if it became law there would be a terrific and rather immediate expansion of both closed panel medical care and closed staff hospital services.

The bill is now being heard in public hearings before Mr. Wolverton's committee. It is receiving vigorous and strong support from certain quarters and very careful attention from the House Committee. Thank you. (Applause.)

SPEAKER CHARNOCK: Thank you, Mr. Hassard.

The report of the Committee on Public Policy and Legislation will be referred to Reference Committee No. 1.

At this time we will have the supplementary report of the Committee on Public Relations. Mr. Ed Clancy.

REPORT OF THE PUBLIC RELATIONS COMMITTEE

MR. ED CLANCY: Mr. Speaker, Mr. President, members of the House of Delegates: This is a brief report of your Public Relations Department presented at the end of one year as you are about to embark upon major policy decisions for the coming year. The decisions you make will, in our opinion, be carried out in a vastly improved public relations climate and will be accepted by a public which has come to appreciate the integrity of the profession, integrity generated by a record of performance. Social and economic pressures revolving around the problems of the delivery of medical care and its payment are not to be confused with the performance of the

personal physician or the collective reputation of the profession.

Representatives of the Public Relations Department have been invited to numerous meetings of the profession in all parts of the state in which voluntary health insurance matters have been discussed. Our part has been to give information, to tell about the actions of other physicians in meeting their local problems. We have avoided meticulously any attempt at direction of the policies, believing that overall decisions are best made by the profession, our job being to implement them once they are made.

In the matter of voluntary health insurance coverage, however, we would like to call attention to a factor often overlooked by the profession. That is that once all employees of a large industry in a comparatively compact community avail themselves of the prepaid medical coverage, that area soon becomes a most barren territory for cultists. The profession, while probably making certain fee sacrifices, is performing a greater service to the gullible, that of actually protecting them against their own ignorance.

Throughout the state your department has given its assistance and encouragement to county societies in establishing twenty-four-hour emergency medical care, making medical care available regardless of ability to pay and establishing public service committee forums where misunderstood patient relationships may be resolved.

This grass roots program is in operation, active operation. For this cooperation we wish to thank the many conscientious physicians in all county societies, large and small, who have made the record possible. The importance of the cooperation of your Executive Secretaries in the larger societies cannot be overemphasized.

Following a fundamental public relations concept of first being good and then telling about it, professional announcements in practically every newspaper in California have made the public aware of your emergency medical care service and the availability of your Public Service Committees. This program of professional advertisement will again be offered to county societies during the coming twelve months.

Copies of the advertisements and many other public relations tools for the profession are on display in our booth in the Galeria. We wish to call your particular attention to our new series of pamphlets on health insurance, fees, emergency medical care and other current subjects. Given the widest possible distribution, we believe they will assist in promoting an even better understanding between you, the personal physician, and your patient.

Along with newspapers, radio and circulars, television is playing an increasingly important part in carrying the message of the personal physician to the public. Your department has assisted in launching these programs in various parts of the state. This new medium is being used or its use contemplated all the way from San Diego to Eureka. Public response in all communities has been far beyond the

professional expectations. The reason is obvious. The public is pleased and delighted to witness the humanizing of the profession and amazed as one writer put it, at the willingness of the profession to give freely from its storehouse of medical knowledge.

The California Medical Association is a co-sponsor of a program originating in Los Angeles and viewed throughout most of Southern California. The mail response indicates why it commands the largest audience of all sets tuned in of the six stations on the air at that time. Up until today's presentation which goes on the air at noon, forty-one previous programs have produced 5,297 laudatory letters. One hundred twenty-three physicians, general practitioners and specialists have appeared on the program. In preparation they have devoted a total of 984 man-hours of their time and service to the general public.

The value of the production, including time and production cost has been—had it been purchased on a commercial basis, would have been in excess of \$40,000.

Incidentally, one youngster wrote, "Please send me a digest of all the adventures of the doctors on your great TV show." (Laughter.)

Many programs have called attention to C.M.A.'s *Health Record* as offered viewers at no cost. Nearly one million California families now use the record to check on their children's health. This letter came from the school nurse of the San Dimas Elementary School District, and is indicative of the reasons for the record's widespread usage.

She said, "Thank you for your prompt reply to my letter asking for the 400 copies of the *Health Record*. The principal and the teachers are very enthused about using them at the end of the school year. We will fill in the information that has been accumulated on their school health records at the end of the school year, when the children take the records home.

"The program 'Ask Your Doctor' is one of the best I have ever seen on television. We try never to miss it. Hope you can keep it on TV for many years."

All of these televised programs are on a public service basis, the station supplying the time, the profession the talent. It is our hope that we may have your continued cooperation in maintaining position. Sponsorship, despite some of the other state association policies, in our opinion indicates a weakness. Commercialism, we are positive, is not in keeping with the dignity of the profession.

In addition to the encompassed and varied services provided routinely for the county societies and best known to the county society officers, on April 25 in this same room we had the unusual pleasure of working with the leaders of the Student A.M.A. in presenting the first annual Public Relations and Office Management Convention for students, residents and interns.

Twelve of your colleagues spoke before an audience of more than 300 young men and women who will soon take their places beside you. The speakers expressed the ideals of the profession and the oppor-

tunities for public service in the private practice of medicine. We believe the meeting was of great value from the standpoint of the public relations within the profession, the welding of the professional ties between the man in practice and the young man about to enter practice. If the Council agrees, we hope to assist in establishing two similar meetings each year, one in Los Angeles and one in San Francisco.

All our efforts, of course, are external. We are the non-professionals. The finest accomplishments are the internal public relations of the profession starting with the professional doctor and the individual patient. The doctor by word and action proves his personal interest in the patient. We heartily agree with a former county society president who stated, "I do not feel that the society should go overboard on spending money on public relations. The best public relations a physician can have is a satisfied patient."

During the past year it has been our pleasure to assist in some of your internal public relations successes through our work with the blood bank Commission, Medical Services Commission, California Physicians' Service, Public Health League, Post-graduate Committee, Rural Health, Audio-Digest and the Cancer Commission. Without meaning to detract from any of the other groups we believe that the work of the California Cancer Commission has been nothing less than magnificent. It is perhaps no coincidence that the insignia for the cancer researchers is a two-edged sword, one cutting into the darkness of the unknown and the other equally sharp slashing away at the cultists and charlatans who for money offer false and unfounded hopes to their patient victims. Your Cancer Commission has given a recent demonstration of its ability to use this second edge in its protection of the public.

For these and many other accomplishments of the profession it goes without saying that we are proud and privileged to be associated with you. Respectfully submitted. (Applause.)

SPEAKER CHARNOCK: Thank you, Mr. Clancy. This report will be referred to Reference Committee No. 1.

Are there any other standing committees which wish to make supplemental reports at this time?

... There was no response. ...

SPEAKER CHARNOCK: At this time then we will have the report of one of the special committees; the Delegates to the American Medical Association, by Dr. H. Gordon MacLean. Dr. MacLean.

REPORT ON DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

DR. H. GORDON MACLEAN: Mr. Speaker and members of the House of Delegates: As chairman of the Delegation to the A.M.A. from the C.M.A. I wish to report that you have a very active, enthusiastic delegation. You also have some very enthusiastic alternate delegates.

Meeting in June in New York, all of your twelve delegates were there. Some seven alternate delegates attended the meeting in St. Louis; all of the twelve delegates were not there but several positions were taken by your delegates, among them Dr. Norman O'Neill and Dr. Burt Davis, and very admirably I must say.

Your delegation works very much like your Council. During the convention, you know, your Council meets every morning here at half past seven. Your delegation to the A.M.A. does the same thing and at that time the various problems of the day and various resolutions are taken up and each individual is assigned to a job; some committee, perhaps, to attend and to report on it the following day. This is the way your alternates gain experience and their education perhaps for future position as delegate.

Now it is a little bit expensive to send your alternates back there. Some of them have gone back each year. I will say that in the past year all of the delegates have gone back. It may not be necessary to send the alternates back to each meeting. I personally believe that if the alternate delegate were sent back to one meeting during his term, his two-year term as alternate, that would be sufficient to give him a good, thorough education of his duties of the future delegate to the A.M.A.

Your delegation does its very best to carry out your wishes. You may find that some of your resolutions have had a little face lifting and have been changed from the time they were presented to the House of Delegates at the A.M.A. The reason for this is that there are many times we believe it is a little wiser from the public relations standpoint to change the expression of certain words.

Inasmuch as at times resolutions put into this House are delayed for a period of six months, you may find that your resolution is not put in even though it was passed. That is only because the resolution has already been passed upon and been put in from some other organization and would do no good to be put in at that time. We are very well represented by Dr. Murray as the Board of Trustees and chairman of the Board, and Dr. Vincent Askey as the Vice-Speaker of the House.

We learn a lot of little things around the A.M.A. We don't get a great opportunity to attend the scientific meetings but I learned a couple of scientific facts while I was back there. One of them I learned I think in the American College of Badgemakers. I don't know if that is the official name but it might well be that name, and that was if you put the badge on your right lapel instead of your left the other individual could see it very much more plainly. This was pointed out by the Public Relations Department of the A.M.A.

Another thing I learned how to do very scientifically is how to wash one of these fast-drying nylon or dacron shirts. You don't have to put it in the bowl at all to wash it. All you have to do, before you go to bed at night, is stand under the shower. Take a shower and wash the shirt at the same time, and when you take the shirt off, hang it on a coat

hanger and in the morning when you get up you look just as sharp and neat and trim as anybody possibly could. (Laughter.) I actually saw this demonstrated. (Laughter.)

You see, we do have a scientific approach to things. I assure you that whenever possible I believe it would be wise to promote your alternates to delegates. These men have been trained and at your expense. I believe also when you are adding new delegates, if it is possible—many times it may not be—to have an alternate put into that position of a new delegate after you have spent money to train him. I am very sure that in the coming year you will find that your delegation will be very active and will do its very best to carry out the wishes of this House. Thank you. (Applause.)

SPEAKER CHARNOCK: Thank you very much, Dr. MacLean. This report will be referred to Reference Committee No. 1.

At this time Dr. Donald Lum, chairman of the Auditing Committee, has asked to make a supplemental report. Dr. Lum.

REPORT OF THE AUDITING COMMITTEE

DR. DONALD LUM: Mr. Speaker, members of the House of Delegates: The budget as recommended by the Council has been submitted to Reference Committee No. 2. I would like to cordially invite any member of the House who is interested in any particular item of the budget or who wishes more information to be present when Reference Committee No. 2 studies and passes on the budget submitted by the Council.

SPEAKER CHARNOCK: Thank you, Dr. Lum. This report will go to Reference Committee No. 2 and you will be able to discuss the budget with said Reference Committee No. 2.

At this time we are going to take a recess until 2:00 p.m. I want to extend an invitation to you before you leave as follows: The Los Angeles County Medical Association cordially invites you to attend the ground breaking ceremonies for the new headquarters building of the Los Angeles County Medical Association at 1925 Wilshire Boulevard at 12:30 today. Governor Goodwin J. Knight, Mayor Norris Poulson and other leaders in the city and county government, representatives of the clergy, officers of the C.M.A. and members of the House of Delegates have been invited to participate in observing this milestone in the eighty-third year of history of our Association. The ceremonies will be brief. We do hope that you will be able to honor us with your presence. Signed, J. Philip Sampson, President; Ben Frees, Chairman of the Board of Trustees.

A bus to the grounds of the Los Angeles County Medical Association ground breaking ceremony will be at the Grand Avenue entrance to the hotel at noon sharp.

If there is no objection from the House, we will stand recessed.

... The meeting recessed at 11:50 a.m. . .

Sunday Afternoon Session

The Sunday afternoon session of the Eighty-third Annual Session of the House of Delegates of the California Medical Association was held in the Renaissance Room, Biltmore Hotel, Los Angeles, California, Sunday, May 9, 1954. The meeting was called to order at 2:00 p.m. by the Speaker, Donald A. Charnock, M.D., who presided.

SPEAKER CHARNOCK: Will you please be seated, gentlemen, as rapidly as possible, as we are ten minutes late.

Dr. Upton of the Blood Bank Commission wishes to make a supplementary report. Dr. Upton, are you here?

DR. UPTON: Yes, sir.

REPORT OF BLOOD BANK COMMISSION

DR. JOHN UPTON: Mr. Chairman, Gentlemen: The California Blood Bank System sponsored by California Medical Association sent by air last week a shipment of blood plasma and serum albumin to our French colleagues in Indo-China. Your Commission, working with the French Government, has inaugurated a program whereby the French Colony and friends of France in California can send blood derivatives to the ill and wounded French Union forces fighting in Indo-China. California medicine already has received several letters of deep appreciation from the Consul General in San Francisco and Los Angeles and from the garrison in Indo-China for its aid in saving the lives of the wounded.

Thank you, sir. (Applause.)

SPEAKER CHARNOCK: Thank you very much, Dr. Upton. That report will be sent to Reference Committee No. 1.

Is Dr. Lester Magoon present?

... There was no response. . .

SPEAKER CHARNOCK: Are there any other reports from the special committees? While we are awaiting the report of the Medical Services Commission we will take up an item which was left off your agenda, report of Reference Committee No. 2, Dr. Robertson Ward.

REPORT OF REFERENCE COMMITTEE No. 2

DR. ROBERTSON WARD: Mr. Speaker, Members: This is the proposition that was left over from last session, not declared an emergency. It is the report of Reference Committee No. 2.

To this committee was referred one resolution. They introduced it at the 1953 Interim Session and it was not regarded as an emergency at that time. This report contains recommendations of the committee on this resolution. This was Resolution No. 3 of the last session introduced by Dr. William Bender of San Francisco which reads:

"WHEREAS, The need of funds has become urgent for purposes vital to medicine, particularly the support of medical schools dedicated to free enterprise and to non-government control; and

"WHEREAS, The trend of dues in our organization on all three levels is ever upward and never downward; and

"WHEREAS, Opulence has led the California Medical Association into ways of extravagance; therefore, be it

"Resolved, That this House of Delegates, without presuming to invade any function of the Council, desires the adoption of the following practices of reasonable economy, in the best interests of medicine in general and of our dues-paying members in particular:

"1. Discontinue the practice, almost unique in state associations, of sending our twelve alternates to either session of the House of Delegates of the American Medical Association annually, as observers, with all expenses paid—travel and \$25 per diem from the time of departure till return—at an approximate annual cost of \$6,000.

"2. Discontinue the \$6,000 annual salary of the Editor of the Journal, also an indulgence shared by few state associations on a comparable basis, a practice which was intended to make possible the employment of a full-time physician-employee with a record of long service in our Association, and not to single out for compensation one among hundreds of our members, also active in practice, who devotes at least equal time and effort without thought of remuneration; and be it further

"Resolved, That the saving of approximately \$12,000 annually shall, if practicable, be applied to the support of medical schools through the American Medical Education Foundation, to supplement voluntary contributions by our members, or to the reduction of dues."

The committee has studied this proposition and reached the following conclusion: With regard to Item 1, we would suggest to the Council the advisability of considering whether almost as an efficient indoctrination of the alternate delegates to A.M.A. might not be accomplished by permitting half of the alternates each year to attend the regular session so that in each two-year period all the alternates would have an opportunity for indoctrination. This suggestion is made to the Council for its consideration and therefore neither presumes to, nor does, invade the function of the Council.

It is the feeling of the committee that regardless of the number of state journals that employ physicians part time as editors, the salary of the editor of CALIFORNIA MEDICINE does not fully compensate him for the time taken from his practice given to editing the Journal. There is excellent precedent for the payment of a decent salary to the Editor of our Journal, for time spent in editorial duties while in the practice of medicine. It is felt that the decision on this salary was reached by the Council after due consideration and that the Council should continue to set the salary of the Editor at a level which it considers just and befitting.

Regarding the second resolve, it will be recalled that the House of Delegates of the California Medical Association voted down a donation by the C.M.A. to the A.M.E.F. at the May meeting in Los Angeles when such a proposal was made by this same committee. If it was considered inadvisable at that time, the mere fact that \$12,000 would be made available by this resolution does not make it any more right now.

Mr. Speaker, I move the adoption of this report. . . . The Chair was assumed by Vice-Speaker Bailey. . . .

VICE-SPEAKER BAILEY: Thank you, Dr. Ward. I take it this is the unanimous report of your committee and therefore it has already been seconded?

DR. WARD: It is.

VICE-SPEAKER BAILEY: Under those circumstances, is there any discussion on the adoption of this report?

DR. LUM: Mr. Speaker.

VICE-SPEAKER BAILEY: Dr. Lum.

DR. LUM: In the resolution that was submitted to the House of Delegates the term "unique" was used as unique in the editor of our Journal being paid as comparable journalists. That is not quite so. I would like to quote the salaries of the part-time editors for comparable journals. *New York State Journal*—the part-time editor who spends one day a week receives \$7,200. I will brief this. The total salary for the editorial staff of the *New York Journal* is \$27,104 a year.

The *New England Journal*, of course, is a weekly journal. The editor's salary there, who works full time, was \$12,500 and it has been raised. The total expense of that journal for editorial work was \$25,262.

Pennsylvania Medical Journal—the editor serves part-time and receives \$5,000 yearly. He has a part-time assistant at \$4,000. Total editorial salaries, \$17,250.

CALIFORNIA MEDICINE editor's salary, \$6,000, full-time assistant to editor, \$8,100. One part-time assistant, \$3,000; total editorial salaries, \$17,100.

So I am sure you see that the amount that is paid to the editor of CALIFORNIA MEDICINE is not out of line.

I urge the report of the Reference Committee be accepted.

VICE-SPEAKER BAILEY: Dr. Cline.

DR. CLINE: Dr. Lum has given you some important information with reference to other states. It so happens that I as an individual and representing the Council was one of those responsible for retaining the present editor. I hesitate to bring personalities into a discussion but I don't see how, since an individual who holds a particular job cannot be unidentified, one may avoid personalities. As of the time that Dr. Wilbur took over the Journal the preceding part-time editor who had become a full-time Secretary and Editor of the C.M.A. had a salary of \$12,000. Prior to his assumption of the duties of

Secretary he had a salary as Editor of the Journal of \$4,000.

During the war there was the realization that *California and Western Medicine*, as it was then called, was not of the standard which we desired to be representative of the California Medical Association and its standards of medicine. The Council decided that changes should be instituted. It asked me and in this room I propositioned Dr. Wilbur to become Editor of the Journal—to become Editor of the then Journal which became CALIFORNIA MEDICINE.

It was with considerable reluctance that Dr. Wilbur agreed to accept that position. He had to be assured that many things which he felt had been difficulties existing in the past would be eliminated before he would be willing to agree to that. Finally I got his consent to accept that position.

I went back to the Council and so reported, and was again designated as the individual to conduct the negotiations with Dr. Wilbur relative to the compensation. Dr. Wilbur said that if he were in a position to do so he would gladly undertake the position without compensation of any variety. On the other hand his situation with reference to practice did not justify his taking the time away. We had luncheon together and as an experimental matter—and it was thoroughly understood by the Council and Dr. Wilbur at that time that this would be an experiment—with reference to the amount of time which would be required. He did not know nor did any of the rest of us know the amount of time which would be required. And a compensation was set on an experimental basis of \$3,600 a year.

As time went on it was obvious that the demands upon Dr. Wilbur's time, because the Editor must read every single item which goes into the Journal. The Editor's position is quite different from that of an elected officer of the Association. A member of your Council may devote a great deal of time, particularly the chairman. Your President-elect and your President give very generously of their time but when they undertake those jobs they know what they are letting themselves in for and those are jobs which participate in or are important policy-making jobs. They are jobs which can be done at odd times according to the convenience of the individual.

There is no deadline as of the 10th of each month when all of the editorial material must be in the hands of the printers so that the Journal may come out on time. That is the situation which confronts an Editor of the Journal. His situation is not in the least comparable to that of officers who do other things.

I think that you heard Dr. Lum's comparison of compensation of the Editor of our Journal and it certainly is not out of line with comparable journals.

As I mentioned earlier, as of the time that he took over the Journal it was one which we could not look upon as reflecting credit upon the California Medical Association. I have heard many compliments indirectly and some directly given to Dr. Wilbur for his excellent conduct of the Journal and the stand-

ards which it has achieved. It has become, I think without reasonable question, the foremost state journal in the country.

I think that perhaps the only regional journal which might be said to occupy a higher position in the estimation of medical people is the *New England Journal* but the *New England Journal* devotes itself almost exclusively to scientific matters. It has therefore a different orientation from our journal, which must concern itself very largely with organizational things. I think that the general approval and recognition and the rise in the esteem of CALIFORNIA MEDICINE in the minds of doctors all over the country can be laid almost solely at the feet of Dr. Wilbur, and I think that there is no excuse for this House to consider anything other than the approval of the Reference Committee's report. (Applause.)

VICE-SPEAKER BAILEY: Dr. Cline, is there any further discussion?

Dr. Bender, what is your report?

DR. BENDER: Mr. Speaker, ladies and gentlemen: Surprisingly enough, I am not going to argue; I am just going to present facts.

Mr. Speaker, I suggest since there are three propositions in this resolution that they be considered by the House separately. The Editor proposition has been started on and I suppose we had better continue that and then go back to the question of alternates and to the last of our items, what to do with the saving, if any. Does that meet with your approval?

VICE-SPEAKER BAILEY: Yes, that is quite satisfactory. Then we all know what we are talking about.

DR. BENDER: I want to make it clear in the first place my resolution was presented entirely on a factual, nonpersonal basis. I want you to know there is no one who respects the Editor more than I do and appreciates the good job that he is doing. So this is a factual and nonpersonal presentation.

My interest was attracted first to the question of savings in the operation of California Medical Association when last year I got a telephone call from Stockton from the secretary of the Committee on Postgraduate Education, asking me to go down to Merced and talk on a program for the remuneration of \$50. I went but I didn't take the \$50. I am old-fashioned enough to believe in my Hippocratic Oath and I did not accept an honorarium. I went on my own.

The other thing that called my attention to the spending of our dues-payers' money was the recommendation of Reference Committee No. 2 last year which requested an assessment of \$25 over and above our regular dues for the support of the American Medical Educational Foundation. As the chairman of that committee has said, this was turned down roundly by the delegates, but it wasn't turned down because of the principle. It was turned down because we felt that we did not have either the legal or the moral power to assess our members for such an amount each year to go for such a purpose.

That the principle was approved is proven by the fact that the C.M.A. sent the constituent county so-

cieties contribution forms to fill out in order to encourage members to contribute voluntarily to this very laudable movement.

Then last year, the first of 1953, the Editor's salary was raised from \$3,500 to \$6,000 and I began to delve around to see just how expenditures were being made and explained. So I explored the field in general and found two areas which I thought were soft as far as extravagance was concerned. One was the routine practice of sending all alternates to the A.M.A. meetings at the expense of the California Medical Association. The other was the salary of the Editor. I looked up all the information I could locally and I made two inquiries, one in November, 1953 and another in March 1954 to all of the other 52 constituent societies of the American Medical Association.

I got a surprising 100 per cent return on the first, which shows extreme courtesy on the part of the officers of the other societies and also probably a little interest in the subject. In the March survey, out of 52 inquiries I got 48 returns. And the results were rather revealing. You may wonder why there are 53 constituent societies when there are only 48 states but they include, of course, Alaska, Hawaii, District of Columbia, the Canal Zone and Puerto Rico.

The results of the survey boil down to something like this: Out of the 53 Associations, including the California Medical Association, there are 38 Associations which have their own journals. One journal, *Northwest Medicine*, supplies four states, and another, *Rocky Mountain Medicine*, I believe they call it, published in Denver, serves five state associations. The rest have no state journals. So far as these statistics are concerned, we are dealing then not with 38 constituent societies but the status of 38 editors, and all these editors are physicians. Of the returns I received, only two of the editors of state medical journals throughout the country are not physicians.

So this concerns the salaries of 38 editors who are physicians. Of those 38, 26 receive a salary. Of those 26 the mean annual salary is \$1,800. There are 12 who receive no salary for their services as editor. If those 12 zeros were included, the mean salary would be \$1,200. The average for the 26 is \$2,449 and the average for the 38 is \$1,675. It is quite true that there is one state society, as Dr. Lum has said, which does pay \$7,200 a year, but that is the only one which does. The others pay less than California's \$6,000 per year.

A number of considerations go into this question which I am not going to explore. I said I want to make this factual, and it is quite true that the Editor has certain duties. He is bound to have, and from my sources I understand he puts in an hour and a half a day, which would be a work-day of seven and a half hours a week. I can't believe that the holder of this job is any different from one who is appointed by the Council to work on a fee schedule committee over a period of years, to head the committee on civil defense, as instances which require a lot of time and a lot of travel and a lot of interrup-

tions, because there isn't any distinction between the work. We are all working for California medicine whether we are an editor, an officer, councilor, delegate or committeeman.

Of course we have a good journal and one of the best, but in my book remuneration shouldn't depend on the quality of service that you give to your fellow doctors. If you want to have some examples a little bit different than those of Dr. Lum, I can cite you for instance *Minnesota Medicine*, which has the same system as ours, that is an editor-in-chief, an editorial board of assistant or associate editors consisting of a large number of specialists who review papers critically and submit them to the editor for final acceptance or rejection. That editor gets no salary from *Minnesota Medicine*, which is a pretty fair medical journal.

Northwest Medicine serves four state associations. The editor is not only scientific editor, he is also the managing editor and he gets \$4,800 a year, and his secretary writes that he puts in between 25 and 35 hours a week.

The *Rocky Mountain Medical Journal*, which serves five states, pays its editor \$1,800 a year.

Illinois, which is a pretty fair sized community, and I have looked at the journal and I understand it is pretty good, pays its editor \$3,000 a year. They pay that to a man who has acted as the secretary-treasurer and editor for many years, 36 years I believe it is, only since his retirement from active practice in order to give him a chance to keep his hand in.

I am perfectly willing to move the deletion of the whereas relative to discontinuation of the salary for the editor, but do believe that this House of Delegates and perhaps the Council when they are considering in the future the expenditures of monies for things of this kind might keep in mind these facts that I have accumulated. So I move the deletion of the resolve relative to the discontinuation of the editor's salary.

VICE-SPEAKER BAILEY: Thank you, Dr. Bender. The Chair is in a little doubt because we seem to have discussed all three things, but I take it to be your thought that you would like to divide it up into three different parts. Is that all right, Dr. Ward?

Well, chiefly it is a matter of keeping it clear before this body. So far we have talked about discontinuing the \$6,000 annual salary of the journal editor, and we have had nothing but arguments in favor of the committee's report, which is that the resolution do not pass. Is there any further debate?

Dr. Bender, if I have misunderstood it I would like to have you straighten it out now.

DR. BENDER: Mr. Speaker, there seems to be some sentiment among those who have spoken and in the report of the committee and of Chairman MacLean of the A.M.A. delegation, to compromise the matter of sending all alternates to A.M.A. meetings.

I think it would be a mistake to defeat the whole resolution by approving the committee's report without discussing the question of sending the alternates.

VICE-SPEAKER BAILEY: Well then, Dr. Bender, we are all understood we are talking about only the editor now and we have so far had nothing—is that correct?

DR. BENDER: That is true, and I move the deletion of the whereas which provided for the discontinuation of his salary.

VICE-SPEAKER BAILEY: Would you like to speak, Doctor? What are you going to discuss?

DR. CAMPBELL: The same thing, the editor.

Mr. Speaker, the course of Dr. Bender's remarks changes my aspect completely. I am not going to talk about Scotland today. However, I am going to talk on finance and I believe when we look into the situation of the editor the small sum of \$6,000 I think is too small. I do not know anyone who would wish to take this position for \$6,000 a year, especially since the journal has been raised in standard far beyond what it was possibly a few years ago.

I would hate to take issue with my old friend Dr. Bender on some of these things but do not let us forget that the love of money is the root of all evil and sometimes when we consider that money should be scrimped, eventually we have to pay much more before we finish. In education it is very important in the whole field of medicine that men be trained. Now sometimes it doesn't mean that we have to be trained in one particular subject at all. It means throughout life. If we are at the bottom, in a hard way, where finance is constantly presented for us we have to fight our way through and win out. Therefore I believe if we start cutting a few thousand dollars for editor and for alternates, we'll be doing an exceptional and great harm to this great state of ours.

Eventually, in a very few years, this state is going to supersede all others in population and in all respects. Now I therefore wish at this time to talk against all the cutting of expenditures for editor or for alternates. Thank you. (Applause.)

VICE-SPEAKER BAILEY: Thank you, Dr. Campbell. There will be no further debate on this subject. I will put the question to the House by considering Dr. Bender's suggestion in the way of amending the resolution by deletion. We have deleted that part about the editor. Do I hear a second to that?

... The motion was seconded. ...

VICE-SPEAKER BAILEY: There is. Then any further discussion on the part about the editor? All those in favor of deleting that portion of the report will say "aye." Opposed?

... There being no further discussion, the motion was put to a vote and it was carried. ...

VICE-SPEAKER BAILEY: The "ayes" have it and it is carried.

Now we go to the main portion of the report which deals with alternates. Part of this has already been discussed. Any question on the delegates? Dr. Bender.

DR. BENDER: I just have some more facts for you again as a result of these polls. Of the 53 constituent

associations of the American Medical Association, 10 associations send all delegates and alternates with expenses paid to meetings of the American Medical Association, including California. Forty-three do not. A rather sad side commentary was offered by Michigan in its return with the simple statement: "A California M.D. talked us into it." (Laughter.)

There are a number of statements that have been made and will be made relative to the importance of orientation of alternates. The committee in its report twice said "indoctrination." I am very sorry they used that term because it gives the impression that the new men are going there to be taught how to think and act rather than to be informed, and I don't think the committee really meant that.

The statement has been made, too, that there are too many reference committees in the A.M.A. sessions for all of our delegation, now thirteen, to attend. I checked that too and there are fourteen, so they would just miss one with thirteen delegates without any alternates.

The question of orientation and preparing an alternate to take the place of his delegate when that delegate retires has been investigated with very interesting results too. I went back over the last eleven years, 1943 through 1953, and I found that the delegates changed ten times and that they were succeeded by the alternates twice, two out of ten in eleven years. That is not including one man who had been an alternate and was subsequently made a delegate in the section of Military Medicine, which hardly represents the California Medical Association.

VICE-SPEAKER BAILEY: Dr. Bender, the Chair doesn't like to interrupt but I didn't understand that. Would you repeat it, please?

DR. BENDER: Yes. During the last eleven years, from 1943 through 1953, according to C.M.A. records, there have been fourteen changes in the alternates. That is fourteen men as alternates have dropped out or died or got tired. (Laughter.) At any rate their names are no longer on the alternate list. Of that fourteen, only two have replaced delegates so that the succession is two in fourteen.

However, during that same time there were ten delegates whose terms ended and who finished their service for some reason or another, seven of whom were replaced by new men, not their alternates. So the statements relative to the training and proving ground of alternates to take the place of delegates as a reason for sending all alternates back to the A.M.A. sessions is not based on fact, as the records here show.

There are a number of other things but, as I say, I am just presenting facts today, so I would offer a substitute "resolve" for that relative to discontinuing the practice of sending the alternates. This is the substitute resolve:

"Be it Resolved, That alternates not substituting for delegates may attend the least distant of the two A.M.A. sessions at C.M.A. expense every other year."

Thus each alternate will gain experience by attending these meetings preferably in staggered fashion so that approximately half of our alternates will attend each year.

VICE-SPEAKER BAILEY: Thank you, Dr. Bender. You have made an amendment then.

Dr. Lum will speak to it—Is there a second to the amendment? Second to Dr. Bender's suggestion?

... The motion was seconded. ...

DR. LUM: Mr. Speaker, members of the House: As a matter of information in the budget prepared by the Council and referred to Reference Committee No. 2, it was a recommendation of the Council that each alternate go to one session during his two-year tenure of office. The reduction in the budget reflects that.

VICE-SPEAKER BAILEY: Dr. Cline.

DR. CLINE: I hesitate to inflict myself upon you again. I am speaking in a dual capacity or perhaps one could say a triple capacity, one as a member of the California Medical Association, one as an Honorary member of the Michigan State Medical Society (laughter) and as a past delegate and past president of the American Medical Association. I am the one who was facetiously referred to in the remark which Dr. Bender made. (Laughter.)

As an honorary member of the Michigan Society I was asked to include in my remarks to their House of Delegates what I thought the value of sending alternate delegates might be. It was upon the basis of that opinion that the Michigan delegates considered that the value that the delegation from California had been to American medicine, that upon the estimate which I gave them of the value of sending our alternate delegates, the Michigan State Medical Society took the action to send its own.

Now there is a lot more to this situation than has been outlined. If I may take your time for a moment to go into a bit of history which some of the younger members of this House may not know—ten years ago there began a revolution in the American Medical Association. Our delegation at that time was composed of some of your still present delegates, not many. It was composed mainly of people who had grown old in the service and no longer represented the thinking of the California Medical Association.

As of that time your former chairman of the Council, Dr. Ed Bruck, introduced a resolution to dispense with the services of Morris Fishbein as editor of the *Journal of the American Medical Association*. That began the revolution. It became essential that our delegation be changed at that time in order to accomplish a number of very worthwhile things.

That project was won and that was essential to accomplish the remainder. The remaining projects were to get a fine, active, thorough Public Relations Department in the American Medical Association. Number three was to get a good representative office in Washington. Number four was to get real, vigor-

ous support on a national basis for voluntary health insurance. That was the California program.

Dr. Murray, who is now chairman of the Board of Trustees of the A.M.A., was the chairman of your delegation. A number of us were members of it. It took a long time. If it hadn't been for the rapidity of events it would have taken much longer to accomplish those changes, which were so apparent to us due to the unfortunate experiences we had had here in California, to bring about a real reorientation of the A.M.A.

The A.M.A. is a much different organization today and it is much different primarily because of the leadership which was furnished by the California Medical Association through the representatives which it sent to the A.M.A.

When it began to send its alternates, because numerically your representation is important—it isn't only a matter of training ground, it is a matter of the people who are there on the scene at the time. Dr. MacLean explained to you this morning the way in which the California delegation has operated ever since I have known him, a matter of meeting every morning at breakfast, a matter of discussing all the issues, a matter of assignment of tasks, a matter of reporting the following morning, a matter of decision on the part of the delegation on the action it is going to take. It has been repeatedly said by many people that by far the most effective delegation in the House of Delegates of the American Medical Association has been that from California.

Numerically inferior to New York still but to no one else, numerically inferior at the outset to about four or five different states, yet the influence upon the course of American medicine and particularly where American medicine with its back to the wall is incalculable, and that is the result of the California delegation.

Now I am going to speak in opposition to the report of the committee and to the action of the Council. I think that it is extremely important that we send our alternate delegates not only to one meeting in two years but to all four in two years so long as they persist because those men have exerted a tremendous influence on the course of American medicine. If the reports I have heard here, which show the change which had taken place in the California Medical Association in the past few years, are an example of the progress that we are sustaining here and that the rest of the country is lagging behind us, in many respects those men can still render incalculable service to American medicine.

Now the C.M.A. officers sought information concerning the payment of various expenses which are slightly at variance with some of the information that was given to you. Travel and expenses of delegates and of alternates who substitute for delegates unable to attend, "yes" 49, "no" 4; living expenses of delegates and such substituting alternates, "yes" 46, "no" 7; travel expenses of all alternates including those who do not go as substitutes, "yes" 10, "no" 43. So this is not such an unusual circumstance. Living expenses of all alternates, "yes" 10,

"no" 43; travel expenses of your officers who were not delegates or alternates, "yes" 20, "no" 32; living expenses of officers, "yes" 20, "no" 32.

Actually this change in pattern as of this last year is the result of the demonstration of the great service to American medicine which the delegation from the California Medical Association has given, and I plead with you not to deny that delegation the numerical strength, and if you wish, the training period for the alternates. (Applause.)

VICE-SPEAKER BAILEY: Thank you, Dr. Cline. The Chair supposed that the reason you spoke of 49 states is for the same reason we have already discussed, state or territory.

DR. FRASER (Alameda County): I think I am the dean of the alternate delegates, and as Rick Reynolds referred to me two years ago when he nominated me for alternate to Gordon MacLean, he referred to the reserves on the bench. And as I recall the last remarks two years ago, he referred to the splinters that the reserves accumulate. Well, we reservists do not accumulate splinters because the chairman of the delegation puts us to work.

I want to concur in the remarks that Dr. John Cline made. I am at the twilight of my medical career in many senses and one, of course, is as an alternate to Gordon MacLean. It has been my privilege to attend better than two-thirds of these conventions and I think a moment of levity sometimes helps. Sometimes people don't appreciate that levity and fun and contact with delegates create good public relations.

Now I may be wrong in this but there are all kinds of jobs to be done in the delegation, the California delegation, and they have been done, I assure you. Vince Askey and these other men are very serious about attending to the serious part of the thing, but there are certain jobs that have to be done like committee hearings and meeting the delegations and getting acquainted with them, and some of us alternates have had to do that. I want to assure you I have had a lot of fun doing it but sometimes, you know, the best public relations are done in politics and in medicine, through the fine, warm contact that you get with people unofficially. It is certainly done unofficially as an alternate, and I think you would make a sad mistake in overlooking the fact that the small cost that it takes to send these alternates back there is well spent.

Now I agree with Dr. Bender—something I don't very often do. However, I believe that if it is worth while to invest money in your alternates I think you ought to see to it that the figures that he mentioned are not repeated. I think he said two out of twenty or something like that. If an alternate is good enough to be an alternate and be paid to go back to wherever the convention is, I think after the first term, two years, then it is up to you fellows to promote him if the occasion comes to promote him, and if not, kick him out.

I think that the alternates, and I speak on behalf of the alternates, have done a swell job the last few

years, and I think it is up to you whether you want to keep them going or not. But I think that from public relations standpoint, and certainly as far as the stature of the California Medical Association in the A.M.A. is concerned, I think the money is mighty well spent. Thank you.

VICE-SPEAKER BAILEY: Thank you, Dr. Fraser. Dr. Murray.

DR. MURRAY: Mr. Speaker, and members of the House: I would like to say a few words about the importance of having our alternate delegates at the A.M.A. I think I have been in position to observe what is happening to the California delegation in the past few years. When I became a member of the Board of Trustees in 1945—that's been nine years—I was told then that the California delegation was more powerful than it had been in the past but not so good as it might be.

Today the California delegation is regarded as the most powerful delegation in the A.M.A. Now I say that without fear of contradiction by the members of the New York delegation, the Ohio, the Illinois, Pennsylvania or any of the others. I have been told that repeatedly. They say that if you want a job done, give it to the California delegation; they will see that it is done.

Now, yes, there's a lot of work when the delegation goes back there and it is a question of their efficiency—their efficiency depends a lot on their acquaintance and you don't become acquainted with these delegates in one visit or in one trip to the House of Delegates any more than you get acquainted here. A young delegate, a new delegate coming in here, doesn't get acquainted with everybody the first meeting. It takes a little while. I have talked that over with our own delegation from Napa County.

Now, I realize that we look at the expenses and it means something, true. I am just about as Scotch as any of the rest of you, but we must look at what we are accomplishing and the welfare of medicine, and believe me these alternate delegates' time is not wasted and neither is the money that you spend in sending them back there wasted. I would like to see the same program continued as in the past because it is an advantage to medicine generally and to California particularly.

Thank you. (Applause.)

VICE-SPEAKER BAILEY: Thank you, Dr. Murray.

If the Chair please, it is of some importance to redefine the issues here so you all know what the vote is to be upon. Dr. Ward, your committee recommended or suggested to the Council the advisability of considering whether almost as efficient an indoctrination of the alternates to the A.M.A. might not be accomplished by permitting half the alternates each year attend the Regular Session so that in each two-year period all the alternates would have an opportunity for indoctrination. This suggestion was made to the Council for its consideration and therefore neither presumes to nor does invade the function of the Council.

Now, to that main motion we have Dr. Bender's amendment which is quite specific and looks as if the House of Delegates would bind the Council and leave them without jurisdiction. Therefore it is for this House to decide whether they wish to vote yes or no on an amendment which will make the terms specific. The amendment is now before you—or is there any further debate on it?

Dr. Green.

PRESIDENT GREEN: Members of the House: It might be to your interest to know that in the A.M.A. there are seventeen Reference Committees and at practically every session that I have attended about six of our experienced delegates have been assigned to some one of these Reference Committees and many times as chairman of such. With only thirteen regular delegates seasoned, educated, informed, it is almost impossible for us to do what you would call a good job with thirteen men. So that is one of the reasons why we have seen fit to spend a little bit of your money to reflect credit upon our own House of Delegates.

VICE-SPEAKER BAILEY: Thank you, President Green. There being no further debate on the entire report as amended—we haven't voted on the amendment yet. All those in favor of the amendment as proposed will say "aye." All those opposed to the amendment.

The "noes" have it. The amendment did not carry. . . . There being no further discussion, the motion was put to a vote and it was lost. . . .

VICE-SPEAKER BAILEY: Then there being no further debate on the entire report, will you move the adoption of the report as amended, Doctor?

DR. WARD: Yes, I would like to move the adoption of the report as amended. Really, the first part of the report has been carried out by your previous vote and I can tell you the reason that the committee reported the way it did is because we didn't feel that we should put any chains on the Council in deciding this matter.

Now, as you have been told, they have already decided to take Dr. Bender's suggestion, reducing the attendance of the alternates, and I would like to move the adoption of the report as amended.

. . . The motion was seconded. . . .

VICE-SPEAKER BAILEY: Dr. Burt Davis from San Jose.

DR. DAVIS: I think we have two things here before us which should be disassociated. We have an economy measure and also we have an appropriation so that I feel that we should delete the last resolve which is the saving should be applied to the support of medical schools, and that should be taken up as a separate point of issue. I should like to propose that deletion.

VICE-SPEAKER BAILEY: Well that is perfectly fair. We divided this thing up in three pieces before, so if anyone wants to speak to that—Dr. Truman, do you wish to speak to that particular point?

DR. TRUMAN: No, I wish to speak to the point of sending the alternate delegates. It is my opinion in discussing this with many of the members of the House of Delegates that the members of the House of Delegates are in favor of sending all the alternate delegates and directing the Council to so do rather than to leave it to the discretion of the Council to send them every alternate year as the resolution as it now stands proposes to do.

VICE-SPEAKER BAILEY: Well, do you therefore make an amendment to that effect the House should so direct the Council?

DR. TRUMAN: I think it should be so made. If it is in order I should so move.

. . . The motion was seconded. . . .

VICE-SPEAKER BAILEY: It is in order. It is moved that an amendment be made to direct the Council to send all the alternates to all meetings. It has been seconded. Are you ready for the discussion? This takes the discretion from the Council.

A DELEGATE: Is that one meeting or two meetings?

DR. TRUMAN: All the meetings.

VICE-SPEAKER BAILEY: All the meetings. This takes the discretion from the Council. The House will vote upon it and it will become mandatory. Any further discussion? Dr. Ward.

DR. WARD: I would like to discuss again—I don't like to direct the Council to do this or do that or not do this or not do that. I think it is the wrong principle, and although I think it is a fine thing to send the alternates to all the meetings, I don't think that as an amendment to this report it should be accepted. I speak on the principle of directing the Council to do this and do that. I think that when we elect the Council to do a job we expect it to do just that and unless it is something that we find that they are doing wrong we shouldn't give them specific directions.

VICE-SPEAKER BAILEY: Any further discussion on whether we shall direct the Council in this amendment? There being none, all those in favor of the amendment will respond by saying "aye." All those opposed?

. . . There being no further discussion, the motion was put to a vote. . . .

VICE-SPEAKER BAILEY: The Chair is in doubt. Will the "ayes" stand, please? Just a minute, a point of information, gentlemen, before we vote. We have to know what we are voting on. The understanding, Dr. Truman, is that the Council shall be instructed to send all of the alternates and all of the delegates to each of the two meetings, am I correct?

DR. TRUMAN: Yes.

VICE-SPEAKER BAILEY: I am correct. That is what you are voting on. The Council will be instructed they no longer have the privilege of deciding, that the House has instructed them to make this movement.

. . . There was a standing count. . . .

VICE-SPEAKER BAILEY: All right. Will the "noes" please stand?

... There was a standing count. ...

VICE-SPEAKER BAILEY: Thank you, gentlemen. Will you sit? The vote is 160 "aye" and 70 "no." Therefore the amendment is carried.

... There being no further discussion, the motion was put to a vote and it was carried. ...

VICE-SPEAKER BAILEY: Now then, Dr. Davis, that finishes your part of the situation because we don't have money. (Laughter.)

Dr. Ward, would you please continue?

DR. WARD: I don't know where that leaves me. (Laughter.) But I am quite in agreement with—was it Dr. Davis who suggested that we take up these things? I suppose this would call for a discussion and a vote of the House as to whether they favor the contribution by the C.M.A. to A.M.E.F.

A DELEGATE: No, no.

VICE-SPEAKER BAILEY: I think that is not in order, Dr. Ward. We are going too far.

DR. WARD: Then, Mr. Speaker, I am confused.

VICE-SPEAKER BAILEY: That is all right.

DR. WARD: I don't know what I am supposed to do up here.

VICE-SPEAKER BAILEY: Just move the adoption of the report as amended.

DR. WARD: I so move. (Laughter and applause.)

VICE-SPEAKER BAILEY: Does anybody second that?

... The motion was variously seconded. ...

VICE-SPEAKER BAILEY: It has been moved and seconded that the report be adopted as amended. Any further discussion? Those in favor will say "aye." Opposed?

... There being no further discussion, the motion was put to a vote and it was carried. ...

VICE-SPEAKER BAILEY: The "ayes" have it.

I would like to thank your committee, Dr. Ward, and Dr. Thomas Hill, and Dr. John Vaughan.

Now, gentlemen, we are going to proceed with the Reference Committee No. 3 report but I would like to remind the new Reference Committee chairman that we have already announced the rooms, but it would be to the advantage of the House if before we start the resolutions the rooms and the times of meeting could be posted on this board over here (indicating). So if you wouldn't mind telling Mr. Thomas when you propose to have the meeting and where, the House would be that much better advised.

Now then, we have Dr. Rosenow, who is Reference Committee No. 3 chairman, a hold-over as you will explain, Dr. Rosenow.

A DELEGATE: A point of information. What is the total number of delegates that can vote?

VICE-SPEAKER BAILEY: Three hundred and one.

A DELEGATE: Three hundred and one?

VICE-SPEAKER BAILEY: Yes, sir. Dr. Rosenow.

REPORT OF REFERENCE COMMITTEE No. 3

DR. EDWARD C. ROSENOW, JR.: Mr. Speaker: All of you have copies of the report of Reference Committee No. 3. I will therefore leave out the whereases and give you just resolves and our recommendations.

VICE-SPEAKER BAILEY: Just a minute, Dr. Rosenow, that sounds to the Chair like a good idea. Does anyone object to it?

... There was no response. ...

VICE-SPEAKER BAILEY: So ordered. Proceed, please.

DR. ROSENOW: Resolution No. 1 introduced by Ewing L. Turner. Subject, A.M.A. Judicial Council.

"Resolved, That Division Three, Chapter XI, Section 10(A) (1) be and it hereby is amended to read as follows:

"(1) The judicial power of the Association in matters of broad general policy and the interpretation of ethical principles shall be vested in the Judicial Council whose decision shall be final unless rejected or modified by the House of Delegates. All opinions of the Judicial Council shall be open to inspection by any authorized representative of any constituent society of the A.M.A. at the headquarters of the Association. Any such opinion may be brought before the House of Delegates by any delegate at any of the three regular meetings of the House succeeding the rendition of the opinion. The House may affirm or modify such opinion or return the matter to the Judicial Council for reexamination."

"It is Further Resolved, That Division Three, Chapter XI, Section 19(A) be and it hereby is amended by adding at the end thereof a new paragraph as follows:

"(7) In matters with respect to which an investigating jury is not requested, the Judicial Council shall observe the following procedure:

"(a) No issue between parties shall be decided by the Judicial Council without affording to each party the opportunity to be heard in the presence of each other either personally or by a representative of his choice both orally and in writing. All parties shall be notified of the time and place of hearing in ample time to make the right to be heard effective.

"(b) No opinion (except decision of specific controversies under paragraph (a) above) shall be rendered by the Judicial Council until at least 60 days after the request for opinion (or the tentative opinion if no request has been made) shall have been published in the *Journal of the A.M.A.* for at least two consecutive issues. Any member of the A.M.A. or a designated representative may present his views on such matter to the Judicial Council in writing and, if any constituent or component society so requests, hearing shall be held at which any recognized medical society which desires it shall be heard by a representative of its choice."

"It is Further Resolved, That the California delegates to the A.M.A. be instructed to support this resolution."

Your committee agrees in principle with the content of this resolution and recommends a "do pass."

Mr. Speaker, I move the adoption of this portion of the report.

VICE-SPEAKER BAILEY: Any discussion on this portion of the report? Dr. MacLean.

DR. MACLEAN: Mr. Speaker, members of the House: I would like to call your attention to the fact that this resolution has already been introduced into the House of Delegates of the American Medical Association and at the present time is in the Committee on Constitution and By-Laws. When they get back there and find that this resolution is already reported on favorably or unfavorably—this perhaps is one of the resolutions that was presented six months ago and at that time wasn't quite adequate or quite desirable, but at the present time there may not be any need to present this resolution.

VICE-SPEAKER BAILEY: Well, Dr. MacLean, will you make a specific recommendation then?

DR. MACLEAN: I would merely make an amendment to this so that if this resolution is not acted upon favorably it be re-presented.

VICE-SPEAKER BAILEY: Doctor, would you like to make an amendment to that effect that if the resolution is not acted upon favorably by the A.M.A. you mean, by the A.M.A., that the C.M.A. then has a chance to re-present it?

... The motion was seconded. ...

VICE-SPEAKER BAILEY: Discussion?

DR. ALESEN: Mr. Speaker.

VICE-SPEAKER BAILEY: Yes, Dr. Alesen.

DR. ALESEN: With all due respect to my chairman of the delegation, Dr. MacLean, I would call his attention to the fact that unless this resolution is adopted by our House of Delegates here and now and instructions given to your delegation of the American Medical Association so to act there will be no opportunity for us to act after a committee of the House of Delegates of the American Medical Association has rendered an unfavorable decision. We are losing our opportunity, in my opinion, which is that it is important to instruct our delegation to press for the adoption of this or some similar resolution.

I will tell you why. There is a certain basic bit of governmental philosophy in here which I think ought to interest you and me very much. Throughout the states, every one of the 48 states, and in the nation as a whole the State Assemblies of the National Congress reserve unto themselves the right to alter and in fact on occasion make decisions by either the Supreme Courts of the states or the Supreme Court of the land. Now one recent instance is the case of our own Federal action overruling the Supreme Court action in respect with the tidelands oil situation. Now, as the Code of Ethics of the American Medical Association now stands it is stated that the opinion of the Judicial Council shall be final, period. All that is requested in this new proposed change, this alteration in the Code of Ethics, is that the judi-

cial opinion or the opinion of the Judicial Council shall be final in matters of general policy and the interpretation of ethics unless altered by action of the House of Delegates.

Now that particular provision is merely reclaiming for the House of Delegates of the American Medical Association the right which it originally gave to the Judicial Council and the right which in my opinion it ought properly to reclaim in the instance of being parallel to our general concept of American jurisprudence.

The other matter of resolution is somewhat secondary; it has been charged, I believe with some degree of truth, that the present Judicial Council is somewhat arbitrary in the manner in which it conducts its hearings and also has been somewhat difficult to approach with respect to giving reports on results of those hearings. Therefore, gentlemen, I urge that you support this resolution as recommended by the committee.

VICE-SPEAKER BAILEY: Dr. Alesen, you are urging that the amendment not pass?

DR. ALESEN: Yes, sir.

VICE-SPEAKER BAILEY: What we are voting on exactly here, your committee reasons principally with the concept of this and recommends that you pass, and the resolution is to instruct our delegation—I beg your pardon, I was going to ask Dr. MacLean the same thing he is going to ask me, to instruct them to support the resolution. Do you suppose we could leave it there, Dr. MacLean?

DR. MACLEAN: Mr. Speaker, with that explanation of Dr. Alesen's I would be very happy to withdraw my amendment.

VICE-SPEAKER BAILEY: The amendment is withdrawn. Thank you. We are all in harmony again. (Laughter.)

Then we go back to the "do pass" recommendation. Is there any further debate? There being none, all those in favor will say "aye." Opposed?

... There being no further discussion, the motion was put to a vote and it was unanimously carried. ...

VICE-SPEAKER BAILEY: Dr. Rosenow.

DR. ROSENOW: Resolution No. 5, introduced by Carl M. Hadley, San Bernardino County. Subject: Intravenous medication by nurses.

"Resolved, That this House of Delegates go on record in promoting legalization of the above procedure by nursing personnel, under medical supervision, and introduce instruction in intravenous technique amongst practicing nurses and into schools of nursing."

Your committee has been informed that the Council has appointed a committee to work with representatives of the California Hospital Association and the California Nursing Association to work out agreed-on procedures with regard to this problem and therefore moves to refer this resolution to the appropriate committee.

Mr. Speaker, I move the adoption of this portion of the report.

VICE-SPEAKER BAILEY: The adoption of this portion of the report is recommended. Do you know which the appropriate committee would be?

DR. ROSENOW: This one that has just been appointed.

VICE-SPEAKER BAILEY: Well, Dr. Charnock and I were looking through this situation and it materializes that he is the chairman of the committee. That is what you had in mind?

DR. ROSENOW: Yes, if that is the appropriate committee.

VICE-SPEAKER BAILEY: That is the appropriate committee. (Laughter.) Dr. Truman.

DR. TRUMAN: Does this give the House of Delegates the opportunity to express whether they are in approval of this resolution or disapproval? In other words, referring it to the committee, would that express our approval?

VICE-SPEAKER BAILEY: No, it is moved to refer to the committee.

DR. TRUMAN: Well, I think the resolution demands an expression of the committee as to our approval of this.

VICE-SPEAKER BAILEY: Would you like to amend?

DR. TRUMAN: Mr. Chairman, I would like to move that the House of Delegates approve the tentative resolution and refer it to the proper committee for action.

VICE-SPEAKER BAILEY: That will be amended first if the House approves it and refers it to the proper committee for action, is that correct, Dr. Truman? Any second to that?

... The motion was variously seconded. ...

VICE-SPEAKER BAILEY: It has been moved and seconded. Any further discussion? All those in favor of the amendment will say "aye." Opposed?

... There being no further discussion, the motion was put to a vote and it was carried. ...

VICE-SPEAKER BAILEY: The "ayes" have it and the amendment is carried.

We now go back to the basic resolution and any further debate on the original resolution as amended. All those in favor will say "aye." Opposed?

... There being no discussion, the motion was put to a vote and it was unanimously carried. ...

VICE-SPEAKER BAILEY: Carried. Dr. Rosenow.

DR. ROSENOW: Your committee assumes that the appropriate committee would act and I am sorry that that was left out of the resolution.

Resolution No. 7, introduced by Burt Davis, Santa Clara County. Subject: The Crippled Children's Program.

"Resolved, That the House of Delegates of the California Medical Association instructs the Council of the California Medical Association and the appropriate committees of the Association to direct their activities toward the following:

"1. The Legislature of the State of California be encouraged to make a realistic legal definition of a physically handicapped child.

"2. That the Legislature be requested to establish methods for uniform practices of social servicing for determining financial responsibility under the act, and, be it further

"Resolved, That the following recommendations be endorsed:

"1. That the family physician be allowed to do those procedures for which he is qualified.

"2. That the services of the family physician be fully utilized in making referrals and in following up the cases under treatment.

"3. That the family physician be furnished with consultation and progress reports, in order that he may be fully aware of cases under treatment which would normally constitute a portion of his practice. And be it further

"Resolved, That the California Medical Association undertake a program of disseminating to its members information regarding the Crippled Children's Services in order to eliminate many of the misunderstandings which have hitherto arisen regarding the operation of this program."

The importance of patients being cared for as much as possible by the physicians of their choice cannot be overemphasized. At present a group of our Council members, namely the Public Health Committee, has been appointed to the Advisory Committee of the Crippled Children's Program and major decisions of the Crippled Children's Program stem from this committee. Until our members on this committee feel legislation is necessary, your Reference Committee feels that pressing for legislation now would be untimely and recommends that this resolution be referred to the Public Health Committee.

Mr. Speaker, I move the adoption of this portion of the report.

VICE-SPEAKER BAILEY: Is there any discussion on this?

DR. DAVIS: Mr. Speaker.

VICE-SPEAKER BAILEY: Dr. Davis.

DR. DAVIS: I hesitate to take up your time on this again but I think there are several points that should be brought out. In the first place we go over these three resolves, the first one instructs the Council to direct its activities toward the following. It does not say that the Council shall immediately see to it that the Legislature make certain changes. It merely instructs them to direct activities toward things that I believe most of us want. One is to have a realistic definition of a crippled child. Two is that there be uniform methods of social servicing.

Now this committee on the Crippled Children's Program, the Advisory Committee to which the Public Health Committee of the Council has been appointed happens to be a committee of approximately twenty-four members. I was recently appointed to it and I attended the first meeting to which I was en-

titled to the day before yesterday. There are only five members, I think, of the C.M.A. or a relatively small group who represent actually the C.M.A. and the Academy of General Practice and other phases of our interest on this committee.

So the statement that major decisions of the Crippled Children's Program stem from this committee which infers that it stems from the Public Health Committee of the Council, I think that that is not quite borne out by the facts.

The Legislature of the State of California a year and a half ago published an interim report of the Assembly on this subject and this matter that a definition of a physically handicapped child was a matter of uniform social service were both pointed out by the Legislature and they requested that something be done about it. I am merely asking that the Council continue to work on the problems, that the matter be kept before the Council and not put off into a subcommittee of the Council, that it be kept before all of us so that some action may ultimately come from it.

Now the second resolve is endorsing certain principles, that the family physician be allowed to do that which he is qualified to do, that he work with the specialist to whom the case is referred, and that he be furnished with consultation and progress reports. None of those things, I think are objected to by any great number of our members. I think that I am not—I know I am not divulging any secret because the committee meeting day before yesterday was open, but one of the matters on the agenda which was seriously considered—no action was taken at this time but it was seriously considered and by two members of the Public Health Subcommittee, it was vigorously pressed, and that was that those people who held Board Specialty Certificates in osteopathic medicine be allowed to take care of these children.

Now I am sure that if that should come to an ultimate fruition that there certainly would be a very great degree of distress and a very great degree of dissatisfaction from the general practitioners among our own group who have been family physicians for many years, taking care of these children.

The third is one that I think the Board of Health would like to have us do. The third one says that this California Medical Association undertake a program to disseminate information to its members so that there will be less misunderstanding, and Lord knows, we all like to have that.

I therefore, Mr. Speaker, should like to amend the report for the insertion of the original resolution in order that it may be carried forth as it has been suggested in itself and these matters be brought before the Council of the C.M.A.

VICE-SPEAKER BAILEY: Dr. Davis, before you leave would you consider eliminating the last paragraph on the present report? Would you care to look at it? In other words, would that do the same sort of thing?

DR. DAVIS: In other words, that brings it back to the original?

VICE-SPEAKER BAILEY: It is your amendment then that we eliminate the last paragraph on the present report. Does anybody wish to second that?

A DELEGATE: Let's hear that read, please.

VICE-SPEAKER BAILEY: The resolve then is to this effect:

"That the California Medical Association undertake a program of disseminating to its members information regarding the Crippled Children's Services in order to eliminate many of the misunderstandings which have hitherto arisen regarding operation of this program."

DR. DAVIS: The three resolutions—the three resolves—

VICE-SPEAKER BAILEY: Well, you better tell us exactly what you want. We could take off that last paragraph which we are going to delete, and I should have spoken of the other:

"The importance of patients being cared for as much as possible by the physicians of their choice cannot be overemphasized. At present a group of our Council members, namely the Public Health Committee, has been appointed to the Advisory Committee of the Crippled's Children's Program and major decisions of the Crippled Children's Program stem from this committee. Until our members on this committee feel legislation is necessary your Reference Committee feels that pressing for legislation now would be untimely and recommends that this resolution be referred to the Public Health Committee."

And that, Dr. Davis, is the paragraph which your amendment proposes to be deleted?

DR. DAVIS: That is correct. Thank you.

VICE-SPEAKER BAILEY: Is there a second to this amendment?

... The motion was variously seconded. ...

VICE-SPEAKER BAILEY: Now all those in favor of deleting that paragraph which will therefore leave the report as it was, as Dr. Davis wrote it, and will make it mandatory that the Council consider this rather than that it be referred to the Public Health Committee.

DR. CAREY (Butte County): As a member of the Public Health Committee that has been meeting with the Crippled Children's Program for the last two years, I came to that committee as a member, a general practitioner, and as one of the most bitter opponents of the ridiculous situation that existed at that time, namely the matter of referral for our crippled children to board specialists and not being cared for by general men. Unfortunately I have had to sit down at the table with a Dr. Hayes and her staff and the rest of the Advisory Committees during that time and I have gradually been forced around to the situation where I am entirely—in almost entire agreement with the program as it is being produced today.

This is not to say that I am entirely satisfied with the program. I am very unsatisfied with it, but I was delegated as a committee of one to define a crippled

child. I think there were some 22 or 23 drafts presented to Dr. Halverson and myself and we have still not truly defined a crippled child, that is actually for the needs of this particular wording.

So much for the first statement of defining a crippled child. I would like Dr. Burt Davis to define a crippled child. Now the other part that I am wondering about here is that the Legislature be requested to establish methods for uniform practices of social servicing for determining financial responsibility under the Act. In this, if we are going back to the Legislature. If we are going to establish laws through our Legislature that will govern the handicapped and crippled children throughout the State of California, we are tackling a pretty big job. We are opening up the whole question of the Crippled Children's Program to the Legislature, every change which must be made in each and every part of the program. On the other hand, there is today a definite constructive move from your Board, from your Advisory Committee to the Crippled Children's Program, which is now being implemented to transfer the emphasis or to transfer the administration of the Crippled Children's Act from the state level to the local level.

At the meeting last Thursday it was said over and over again that we are after—we want to place in the county's hands the matter of taking care of the local Crippled Children's Program. I cannot quote to you direct figures but many of our large counties in the state of 50,000 population or more are not handling Crippled Children's Programs on their own. They are urged to do so. Your Council was told at this last meeting that the Crippled Children's Program wants to implement this particular recommendation from the Crippled Children's Program. If this is brought down to the local level your own social service program will be able to take care of the situation at that time.

Besides that the Crippled Children's Program this year has appropriated additional funds which will almost entirely take care of the additional administrative expense of handling and administering the Crippled Children's Program at the local level. If you could get these cases down at a local level I maintain—I think then you could do a much better job of social servicing. I think you could do a much better job of referral. I think you could do a much better job of handling the particular program.

As a matter of social servicing I offered the case that happened, just came to my attention three weeks ago from the Superintendent of Schools of our particular area who is having his child's teeth straightened at the expense of the Crippled Children's Program. I am not particularly happy about that but I don't know what I am going to do about it through the Legislature. I do think that we can do a great deal about it if I could ever catch him over at the Welfare Office for a few minutes, and I think the same thing applies to the rest of the state.

"That the services of the family physician be fully utilized in making referrals and in following up the cases under treatment."

Again that is a matter of activity.

"That the family physician be furnished with consultation and progress reports . . ."

That is a matter that came up almost a year ago at our last meeting on this, that they need to be implemented, and at least we are urging it. To those of you who are on the Council, Public Health members from the Council who are serving on that, when I think all of us can say that we are very much in agreement with the program that is being implemented, and as we are attempting to direct it at the present moment—now I would just not like to have this sent as a mandate with this legislative feature in it, and I think that probably the best answer to this particular program is to adopt the resolution as presented by your Reference Committee.

VICE-SPEAKER BAILEY: Thank you, Dr. Carey. Dr. Carey, then you are speaking against the amendment?

DR. CAREY: I was.

VICE-SPEAKER BAILEY: Is there anything further on the amendment?

DR. YOUNG: Mr. Speaker, Young is my name. I am from Fresno.

Members of the House: I wish to speak to the proposition as submitted by the Reference Committee.

VICE-SPEAKER BAILEY: Well, Dr. Young—

DR. YOUNG: I wish, Mr. Chairman, to speak to the amendment as submitted by Dr. Burt Davis.

VICE-SPEAKER BAILEY: Surely, either for or against?

DR. YOUNG: I am speaking in favor of the amendment as submitted by Dr. Burt Davis.

I am from Fresno County and many of the physicians of the San Joaquin Valley are very unhappy with the Crippled Children's law as it now stands, and we believe that probably the only relief that we can obtain from this law is constituting the Advisory Committee for Crippled Children Services because, actually, as it is named this is an Advisory Committee and all it can do is to advise the administrators of this law. And in order to change this law the Legislature must take action, and certainly the Legislature will listen to the Advisory Committee, I believe, if the Advisory Committee is properly advised by this House.

At the present time the definition of a crippled child in this law is very, very lax and there is nothing in the resolution as presented by Dr. Davis which attempts to specify what a crippled child is. His resolution has specifically left it to the appropriate committee of this Association and of the committees of the Legislature. The present law as it now stands has absolutely no limitations placed upon the specifics of these services except as to residence.

There is nothing said in the law which states there shall be any financial responsibility on the part of the children or the family of these children who are treated by this law. They are, however, in all fairness according to the meeting of the day before

yesterday, attempting to set up rules and standards of financial responsibility but, mind you, nothing is said in the law about those whose financial responsibility—so that it appears to us or to many of us in the San Joaquin Valley that in order to get relief on some of these issues the Legislature itself must take action and we must not leave this to an Advisory Committee of the Crippled Children's Services.

Nothing is said in the law pertaining to a panel of physicians but actually in practice there is a panel of physicians set up by this law. The law states that over and above the license that is granted to us by the State of California and over and above the degree of Doctor of Medicine granted to us by the medical schools of this nation that certain other qualifications must be met.

It is the opinion of many of us they are rather arbitrary and that we feel that the best interests of the children of this state are not being served by setting up a restriction upon them as to who shall treat them in their illnesses. We are of the opinion that if this law can be liberalized, the best interests of the children of this state will be served and that is the purpose for our recommendations to you.

We are of the opinion that this law has been abused and will continue to be abused as it now stands, and we are also of the opinion that as this law is now emphasized by various members of this profession, it is adding this community to its ranks and certainly that we cannot stand. And I set before you this proposition that if we are to devote so much of our time and energies in this House to opposing closed panels that are financed by private finances, that we are derelict in our thinking and we are derelict in our duties and to our patients in affirming the closed panel system of medicine as financed by the state. (Applause.)

And I submit to you this proposition, too; so long as we as a profession are so inconsistent as to accept this type of closed panel system as financed by the state and not fight it and reject it by those organizations that can financially pay for it, then we most justly and we most inevitably deserve the fate that will surely come to us.

I submit to you, ladies and gentlemen, that the Crippled Children's law as it is now written is not in the best interests of the children of this state; I believe it should be changed and I believe that the only place that it can be changed is through the Legislature of the State of California. It appears to me that the members of our profession who sit on that committee as advisors to the administrators of that committee can have their hands reinforced no end by an unequivocal action of this House stating that we like an open system of medicine and the law must be changed.

Thank you, Mr. Chairman.

VICE-SPEAKER BAILEY: Thank you, Dr. Young. (Applause.)

Just to keep the House perfectly clear, do you propose to speak for or against the amendment?

DR. REAVIS: I propose to speak for the amendment.

Mr. Speaker and members of the House: I am an internist who is a member of the panel which has to do with the treatment of crippled children. My special connection with this is as a cardiologist in my community and I am speaking in favor of Dr. Davis' proposition which he has now reinforced with his amendment. I feel that the method with which this thing is handled, even though I am a member of a panel, is quite unfair and I want to point out one example which has come to my attention in the treatment of these people.

I had under my care, referred to me by the Crippled Children's Program of my own county, a 24-year-old woman who has had two children, whose husband is fully employed as a baker. Thank you. (Laughter.)

VICE-SPEAKER BAILEY: Dr. Davis, the Chair gets the impression that everyone is in favor of the entire subject and it is just a matter of getting the exact implementation.

DR. DAVIS: I wish to speak in answer to some of the statements that Dr. Carey has made. It is quite true that the Board of Public Health and the Advisory Committee on Crippled Children's Services are working as hard as they can in an effort to decentralize the program and get it back to the grass roots level where everyone can see who is digging into the barrel and walking off with the swag. (Laughter.)

It is quite true that the Advisory Committee is working on a guide for the information of those people in welfare departments and health departments who have to social service this program. It is also and equally true that the definition that is laid down by law in the statutes of what constitutes a physically handicapped child is so loosely written and is so broadly interpreted that it will include almost anybody below the age of 21, and you will remember a few years ago there was a proposal in Congress that this be extended to pass recipients after they reached the age of 21 and until they got to be 45. That doesn't give them very long before they go on Social Security, so they only have a few years in which they are on their own. (Laughter.)

Now this first resolve is not compulsive. It is permissive and it places the matter frankly in the hands of the Council where it should be. Dr. Carey, and I don't wish to deprecate Dr. Carey's efforts or his committee of one in making a definition. He has invited me to make one, and at the appropriate time I can assure you that I have brought out a definition which will be introduced as a resolution under New Business. (Applause.)

VICE-SPEAKER BAILEY: We have something to look forward to. Is there further debate? This is on the amendment now.

We shall delete the last paragraph, and that is in effect putting the matter before the Council instead of referring it. All those in favor of the deletion of the last paragraph will respond by saying "aye." Opposed?

... There being no further discussion, the motion was put to a vote and it was unanimously carried ...

VICE-SPEAKER BAILEY: The last paragraph is herewith deleted. (Laughter.)

Now then, we will go back to the entire proposition. Those in favor of the resolution 7 as stated say "aye." Opposed?

... There being no discussion, the motion was put to a vote and it was unanimously carried. ...

VICE-SPEAKER BAILEY: Carried. Will you continue, Dr. Rosenow?

DR. ROSENOW: I wouldn't like anyone in the House to think that we were against the intent of this resolution. We thought that we had a way of getting at it.

Mr. Speaker, I move the adoption of the committee's reports as a whole as amended.

VICE-SPEAKER BAILEY: Is there a second to that?

A DELEGATE: I second the motion.

VICE-SPEAKER BAILEY: Dr. Truman.

DR. TRUMAN: Mr. Speaker, I would like to move the reconsideration of Resolution No. 5. It appears that in our convention, according to the Legal Counsel, Mr. Hassard, we have inadvertently moved and voted that we shall go on record as promoting legislation. I am sure that none of us feels that is necessary or desirable at this time, and therefore I move we reconsider this and that in our reconsideration we amend that resolution on the bottom of page 2, delete the words "in promoting legislation" and change those "as approving" and in continuation of the second line of that resolution we introduce "of the above procedure by competently trained nursing personnel."

The resolution then would read:

"Resolved, That this House of Delegates go on record as approving of the above procedures by competently trained nursing personnel, et cetera."

Mr. Speaker, I move the reconsideration of this resolution and its amendment as I have suggested.

VICE-SPEAKER BAILEY: Dr. Truman has moved to reconsider and this is in order. The Chair has to ask you whether you voted with the affirmative, Stan. If not we will have to talk about rescinding. You did vote with the affirmative, Stan?

DR. TRUMAN: Yes.

VICE-SPEAKER BAILEY: Therefore it is in order. Any second to the move to reconsider?

A DELEGATE: I second the motion.

VICE-SPEAKER BAILEY: Now, Dr. Truman, I suppose you should restate this but I think you have pretty well done it already. Simply read this again so that we have that one resolve, the whole thing in mind.

DR. TRUMAN: I move that the resolution be amended to read:

"Resolved, That this House of Delegates go on record as approving of the above procedure by competently trained nursing personnel, et cetera."

VICE-SPEAKER BAILEY: Thank you very much, Dr. Truman. Is there a second to that?

A DELEGATE: Second the motion.

VICE-SPEAKER BAILEY: Is there any discussion? Those in favor of the motion will say "aye." Opposed?

... There being no further discussion, the motion was put to a vote and it was unanimously carried. ...

VICE-SPEAKER BAILEY: The "ayes" have it.

We have before us the main proposition of adopting the report as amended. All those in favor will say "aye." Opposed?

... There being no discussion, the motion was put to a vote and it was unanimously carried. ...

VICE-SPEAKER BAILEY: The report is adopted.

There has been a suggestion made from the left hand side of the table that we have a ten-minute recess but Dr. Charnock has some ideas.

... The Chair was assumed by Speaker Charnock. ...

SPEAKER CHARNOCK: We have a lot of business to conduct yet, gentlemen. If you want a recess you can vote on it. I am surely hearing no clamor.

At this time we have now finished the hold-over reports from Reference Committee No. 2 and Reference Committee No. 3. We still have the report of a Special Committee, the Medical Services Committee, Dr. Leslie B. Magoon. Dr. Magoon.

REPORT OF THE MEDICAL SERVICES COMMISSION

DR. LESLIE B. MAGOON: Mr. Speaker and members of the House of Delegates:

At its Interim Session last December this House referred two resolutions to the Medical Services Committee for study and recommendation. The study is not yet complete but a progress report can be given.

The first resolution concerns the devising of a uniform claim form for health and accident insurance purposes. Preliminary investigation revealed that the commercial insurance companies were well along on an identical project of their own, and that if the medical profession were to participate in the devising of such a form, action should be prompt.

The Commission therefore appointed a subcommittee, of which Dr. William Kaiser of Berkeley has consented to be chairman, to confer with them to achieve a meeting of the minds so that any uniform claim form would meet the needs of both parties immediately concerned.

This subcommittee has not yet had time to get very far along in its work but the Commission has full confidence that its task will be prosecuted to a successful conclusion.

The second resolution concerned cost accounting studies of medical practice to determine the least as well as the more obvious cost of medical practice with the objective of relating fees to those total costs. The Commission has accepted as desirable the accumulation of such data as will review the total cost of rendering medical care, hidden as well as appar-

ent, but is as yet unconvinced that there is any necessary relationship between these costs and professional fees.

In the experience of the Commission studies such as these should first be tried out on a limited pilot scale before comprehensive statewide surveys are undertaken. On this basis a subcommittee of the Commission, chaired by Dr. Lester Lawrence of Oakland, is currently exploring the costs of such a pilot study so that they may be weighed against the possible benefit.

When this decision is made it will be referred to the Council as a recommendation of the Commission.

A further word should be said about the County Medical Society Health Insurance Study Committee. It existed only a short time. They already have demonstrated its value not only as an important mechanism for studying the big question of health insurance but as a means of educating our membership at large and as a most important method of achieving cooperative effort on the local level between the profession on one hand and the insurers and beneficiaries on the other.

The findings of these committees have duplicated those of the Commission, as a free give and take, of a round-table discussion, and have led to a much greater degree of understanding. The Commission urges again that no effort be spared by either the California Medical Association or the component societies referring to the activities of these county study committees.

Changing times, changing economics, changing social thinking, and changes in medical practice itself have posed a challenge to medicine which the profession has been slow to recognize and even slower to meet. That challenge is a question, more and more often asked by more and more people: Is the traditional method of rendering medical care to the people really the best?

We define the "traditional method of rendering medical care" as the individual, free, private practice of medicine on the economic basis of the fee for service determined by the ability of the patient to pay. And we define "the best" as "furnishing the highest quality of medical care at a cost within the means of the people."

This challenge is divisible into three components, each of which can be documented to be a widely held public feeling:

1. Public dissatisfaction with the "fragmentation" of medicine into specialties, with the resulting disappearance of the public's old ideal, the family doctor.
2. Public resistance to the traditional practice of basing medical fees upon the ability of the patient to pay.
3. Public desire, which has grown in the public mind to the stature of a necessity, for a method of paying for medical care by regular, monthly installments of a fixed amount.

The position of the medical profession in the face of this challenge has not been happy. Doctors have had to admit that specialization has resulted in the "fragmentation" of which the public complains, even while insisting that the increasing complexity of medicine has made specialization not only inevitable but in the best interest of the patient. Doctors point out that the fixing of fees on the basis of ability to pay has been to the advantage of the poor patient, and has been concrete evidence of the adherence by the profession to its obligation to furnish medical care in spite of the inability of a patient to pay.

To the physician, it seems to follow that if the factor of ability to pay is fairly applied to the poorer patient, it is equally applicable to the richer. To the public demand for some method of prepayment of, or of insurance against, the costs of medical care, the profession has offered much less resistance. Doctors are quite convinced of the desirability of some such mechanism—their opposition has been limited solely to those drastic changes in the traditional method of medical practice which a good prepayment mechanism has too often seemed to require.

Growing public pressure, based on the public feeling we have described, has steadily been weakening the position the medical profession so far has taken that the traditional methods of rendering medical care are still the best. And to this pressure of public opinion has been added the potent economic force of competition from the closed-panel capitation plans of prepaid medical care. These, by exploiting the public feeling against the asserted weaknesses of the traditional methods of medical care, have become a powerful threat to the private practice of medicine.

How well the closed panel capitation plans meet the criticisms of private individual medical practice is only too clear. They avoid public dissatisfaction with fragmentation of the profession into specialties by grouping all specialties under one roof and under one control; they eliminate the fee for service altogether; and they make possible full prepayment for all medical services. So well, indeed, does the closed panel capitation system appear to answer the public demand that two things have happened: A large segment of the public, and their political representatives in government, are convinced that this method of rendering medical care is the final answer, and are engaged in all sorts of activities to promote more and more facilities of this kind; and a growing segment of the public is deserting the individual private practitioner to become beneficiary members of such plans.

So long as the pressure for change in medicine was limited to that of public opinion (particularly since the threat of governmental intrusion had waned), the profession regarded the problem on the plane of theory, and was slow to transfer theory into practice. But when closed panel capitation plans developed as an alternate kind of medical care, it became obvious that the time for academic discussion was past and that those practical steps necessary to make

it possible for private medicine successfully to compete with these plans had first to be plotted and next to be taken. The whole purpose of this report is to name those steps.

It is almost superfluous to say that California physicians have exhibited a great degree of concern and no small degree of irritation at this development of a competing kind of medical service. The concern stems, of course, from the fact that as more and more patients turn to closed panel capitation plans, the physicians' own practices suffer and their own personal futures as individual private practitioners will seriously be endangered.

But their concern is based, too, on the belief that the quality of medical care available to subscribers of such plans has a tendency to deteriorate through the years. Thus the fine quality of medical care and the high standards of medical practice which the medical profession has so zealously guarded may seriously be compromised by continued growth of this type of organization.

The irritation of the profession has been less rational. It has taken the principal form of assault and criticism directed against a single closed-panel capitation plan which, to the physician, has epitomized and personified all the defects he believes to be inherent in this type of organization.

We call that irritation and its results poorly justified because they are based upon the obviously untenable premise that if this one plan could be eliminated, competition from this type of plan likewise would end. Nothing could be further from the truth. A great many people have been convinced that closed panel capitation plans are good, and good for them.

If such a plan were not available from its present source, some other similar plan would very soon fill the gap—no strong demand of the American people for any given product is long unsatisfied. And, in the meantime, should this one plan have been forced out of existence by any act of organized medicine, its beneficiaries and supporters would bitterly resent this effort by "the entrenched reactionaries associated with the American Medical Association" to hamper their participation therein.

The medical profession should oppose experimental plans only where it can be demonstrated that such plans are truly harmful to sick people. Many people seem sincerely to want the kind of medical service offered by the closed panel capitation plans, and it is difficult for the medical profession to deny that there is a place in our social and economic environment for plans of this kind. To proceed upon the assumption that only the medical profession knows what is good for people and should therefore attempt to legislate or by any other means dictate what kind of medical care plan should be made available to people is to be naïve.

The only apparent good answer by the individual practitioner of medicine to this different kind of medical practice is the competitive, free-enterprise one of offering a better product. And the base upon which this better product must be built must be the

ethical consideration that "the welfare of the patient is the first concern of medicine."

The blueprint for our product has long been in our hands, but we have hesitated to translate it into the structure we must build. That blueprint is the "personal physician" concept as it was developed by Dichter and by Waterson in his "projection" of Dichter's report. The personal physician concept can be a full answer to public irritation with fragmentation of the medical profession into specialties. Inherent in it is the virtue of high quality, personalized, sympathetic care of the whole person, and it is the one kind of medical care that a closed panel, by the very reason of its being a panel, cannot give.

The services of a personal physician are the one thing that the private, individual physician has to sell which no purveyor of medical care under any other system of medical practice can offer. If the virtues of this kind of medical care be not enough to make people want it, then doctors must change gracefully to conform to the trend of our time and the needs and desires of the people we serve. If, on the contrary, this is the kind of medical care that people want, the medical profession must vigorously promote, and even further enhance the quality, of medical care rendered by the personal physician.

This, then, is our product—personalized, high quality medical care that only the individual, private practitioner of medicine can render. How, and on what financial terms, shall we sell it?

To borrow commercial phrases, experience has demonstrated that our product will not sell for cash in competition with the closed panel product which can be bought on time. Even high quality cannot be sold if its cost be beyond the consumer's financial ability to pay. To argue that the total cost of high quality medical care is no more than the nation's tobacco bill is to beg the question—total costs mean nothing to the individual whose individual costs are beyond his reach.

The analogy suggests our solution: The total costs of medical care must be spread so that individual cost is a pro rata of the whole, and might therefore be comparable to the individual tobacco bill. The conclusion has to be that, to sell our high-quality product, its costs must be met by some method of group payment for individual expenses—a mechanism for which the misnomer "prepayment" is a commonly accepted name.

Why has it been so difficult to devise a satisfactory prepayment mechanism applicable to individual, private medical practice? The answer is simple—the unpredictability of the costs of medical care rendered under this system of medical service. The very essence of private practice has been the fixing of fees upon the basis of the ability of the patient to pay.

But this variability, with its consequent wide fluctuations in medical charges for what appear to be identical services, has either of two results. It makes determination of a premium for insurance against full costs impossible, or, if a realistic premium is to be fixed, makes it necessary to provide a schedule

of benefits which may have no relation at all to the costs they are intended to defray.

There is one way to resolve this problem: Arbitrary fixing of uniform fees for all physicians by edict, as is done by the California Physicians' Service plan, and as would be done under any form of state medicine. There is, however, a better way short of such drastic fee regulation from above. That way was pointed out by the Study Committee report, and has been redescribed and clarified by the Medical Services Commission in its report upon the report.

Briefly stated, these reports recommend that pre-determinability of medical costs can best be attained without loss of any important degree of freedom by the individual physician by substituting for the ability-to-pay concept the principle that each physician develop his own list of charges which are uniform within his practice.

This principle is well outlined by Mr. Waterson in "Doctor and Patient" as follows: "The doctor's fees should not be increased above his estimation of the actual value of his services but should be confined to each doctor's own self-determined constant fee schedule. Deviations should only be downward—for inability to pay the normal fee—unless it is previously expressly understood that the patient demands, can afford, and expresses his willingness to pay for, more time and attention from the doctor than adequate care would normally require."

By adding to this concept its belief that there is a definite trend for physicians in any given community to set their individual fees within a relatively narrow range of variability, the Study Committee proposed that the mode (the value that occurs most frequently) of this narrow range could be considered the "usual fee" in that community. This "usual fee" then could be the basis upon which adequate coverage by indemnity insurance could be possible. The combination of individual fee schedules, the community usual-fee list and adequate indemnity insurance the Study Committee called the "Average-Fee Plan," and the Medical Services Commission has presented under the general title "The Usual Fee Indemnity Plan."

The Medical Services Commission is convinced that this is a useful and promising approach which, if properly understood and supported, would go far toward enlisting more vigorous support of medical care insurance by the medical profession, as well as satisfying the public demand for certainty and adequacy of coverage.

It is important to remember that indemnity plans furnish money to pay for medical care, but service plans furnish medical care. No service plan, and that must include C.P.S., can function without some degree of control of both patient and physician—it must to some degree be master of both. With no built-in incentive for either patient or physician to limit costs, and with the need for a statewide, uniform, fixed fee schedule whose level is determined solely by the income of the plan, the need for artificial control of both beneficiary and doctor is undeniable.

Indemnity plans, however, make the insurance agency the tool of the patient but not the master of the doctor, and allow each doctor to retain control over his own fees. The only kind of prepayment mechanism applicable to the individual, free, private practice of medicine is indemnity insurance. It should be superfluous, then, to belabor the point that the medical profession must take whatever steps are necessary to make indemnity insurance a good and adequate method prepayment. The Medical Services Commission is certain that the shortest, most conservative step in that direction is full implementation of the Usual Fee Indemnity Plan.

The Medical Services Commission therefore recommends, as the long-range program of the medical profession as it is represented by the California Medical Association, the following:

1. Vigorous prosecution of the "personal physician" concept as the basis of the kind of organization of medical practice which will result in the highest quality of medical care for the patient.

2. Implementation as rapidly as possible of the Usual Fee Indemnity Plan as being a good solution of the problem of the application of prepayment to the individual, free practice of medicine.

The Commission, in cooperation with Mr. Rollen Waterson, has prepared and presented to the Council the exact specific steps and activities which it believes should be followed to accomplish these objectives. They are at once too detailed and too obvious to require inclusion in this report to the House. No further authority for the implementation should be necessary if this broad outline of policy is adopted.

There still remains a problem—one of time. The success of the Usual Fee Indemnity Plan will depend upon education to obtain voluntary cooperation based upon the conviction of each individual physician that his acceptance of the principle of individual uniformity of fees is necessary to the preservation of private, individual medicine.

That education will take time and will be effective only in the not-near-enough future. A comprehensive prepayment plan for immediate application, even upon the admitted basis of a temporary stop-gap, is demanded by many of our component societies to meet the threat or actuality of closed panel competition.

The only such immediately available plan which permits free choice of physician in a framework of private, individual practice is an extension of California Physicians' Service's present service plan. In spite of the Commission's opposition to service plans in principle, we cannot feel justified at this time in opposing the use of an extended C.P.S. service plan by those county medical societies who feel that they need it as an immediate answer to their problems.

There can be little doubt that C.P.S. with its present income ceiling fails to be an adequate answer. With its present program, C.P.S. falls short of providing comprehensive coverage for anyone, and fails by a wide margin to provide adequate, certain coverage for those families whose incomes are above the

existing ceiling. Raising this ceiling may make of C.P.S. a more immediately useful weapon in the competitive battle with the closed-panel plans. After consultation with the C.P.S. administration, it is suggested by the Commission that to gain this end, a family income ceiling of \$6,000 should be set.

The Commission, however, is unwilling to recommend that this increase be uniformly applied statewide. There are many counties in which the threat of panel competition does not exist, and in which time to implement the Usual Fee Indemnity Plan still remains. Many counties will be resistant to an increase in C.P.S. income ceiling on the basis of their opposition to the service principle for any but low paid persons, which we have already said the Commission shares. The resistance of these counties might well prove to be sufficiently great to hamper C.P.S. operations and therefore in the long run to be to the disadvantage of C.P.S. as well as to discredit this entire approach by the California Medical Association.

On the other hand, an increase of the income ceiling on a strict local option basis is admittedly impractical because of two conditions: The frequent need to negotiate coverage from groups with members in several communities throughout the state, and because many covered individuals work in one county and live in another.

A workable solution to this dilemma has been devised and proposed by Mr. Waterson. He suggests that an increase in the income ceiling in any county be made only upon request by formal vote of a county medical society. C.P.S. will then sell the contract with the higher ceiling only in that county, but C.P.S. physician-members in other counties will accept the obligation of caring for holders of these higher-income ceiling contracts on the same terms as will those of the county wherein they were sold.

The same theory would be applied in contracts for statewide coverages—the county wherein the largest number of beneficiary members were employed would make the decision whether or not to request the higher income ceiling and that decision would be honored by physician members in all other counties in the state.

The Medical Services Commission therefore proposes the following revisions in C.P.S. operation, to be recommended by this House to the Board of Trustees of C.P.S.

1. The present C.P.S. \$4,200 income-ceiling contracts shall continue undisturbed.
2. A separate and distinct contract with a \$6,000 ceiling, sold at a higher dues cost and paying a higher fee schedule, shall be made available for sale in those counties which, by vote of the county society, request this program.
3. It shall be made a condition of physician-membership in C.P.S. that physician members, wherever located, shall honor the terms of the higher income ceiling contract in rendering medical care to any holder thereof.

The Commission is fully aware of the possible confusion and difficulties that may be entailed in the operation of a double program by C.P.S. But experience in other states with a double, or even a triple, income ceiling, and consultation with C.P.S. administration, make it seem that these may not be too great. The Commission believes that this program is worth a trial, and we are certain that decision on matters of this gravity should, to as great a degree as is possible, be made on a local-option basis.

By these recommendations, the Medical Services Commission has outlined a short-term program to fill an apparent immediate need, and a long-term program which comes as close as seems possible to us successfully to meet the challenge of "changing times, changing economics, changing social thinking, and changes in medical practice itself." I am sure that we have gone further than some of you approve, and not as far as others of you would like.

Perhaps that fact will persuade you that there may be merit in our proposals as being the mean between the extremes of "do nothing" and "do everything." We advocate neither, but we do advocate that we "do something"—so long as the result of that "something" is even higher quality, personal medical care whose costs are met by a prepayment plan which neither distorts or dominates the private, individual practice of medicine, in the basic virtues of which we still believe. (Applause.)

SPEAKER CHARNOCK: Thank you very much, Dr. Magoon. That report will be referred to Reference Committee No. 1.

Are there any other special committees or standing committees which wish to make supplemental reports at this time? The Chair hearing none, will ask that the Secretary advise if there is any old or unfinished business. If there is no old or unfinished business, according to the by-laws of this Association the Council may elect to recommend to the House of Delegates that an Interim Session be held. They have not so recommended and for that reason resolutions and other new business introduced at this session must be acted upon during the current Annual Session. We will now accept the introduction of resolutions.

... The Chair was assumed by Vice-Speaker Bailey. ...

VICE-SPEAKER BAILEY: Dr. Shipman, do you have resolutions?

DR. SHIPMAN: Mr. Speaker, a few minutes ago the Speaker, Dr. Charnock, ignoring the fact that our program for these sessions begins correctly with the House of Delegates agenda used the term "Agendum." The Council has attempted to correct that, and to correct Dr. Louie Alesen, from whom I suppose he got this error, on a number of occasions. It is a matter of regret to have to point out that he made that error today. I suppose the only explanation is that he comes from south of the Tehachapis. (Laughter.)

The Council would like to introduce the following resolutions:

RESOLUTION No. 1

WHEREAS, Dr. William Henry Geistweit, Jr., has been a member of this Association for thirty-three years and has served well and faithfully as secretary of the San Diego County Medical Society for twenty-eight years; and

WHEREAS, This service qualifies him for such honors as the Association may bestow upon him; and

WHEREAS, Dr. Geistweit has retired as secretary of the San Diego County Medical Society and has limited his medical practice; now, therefore, be it

Resolved, That the House of Delegates confer upon Dr. Geistweit Honorary Membership in the California Medical Association, effective January 1, 1955.

VICE-SPEAKER BAILEY: This will go to Reference Committee No. 3.

DR. SHIPMAN: The next resolution is:

RESOLUTION No. 2

WHEREAS, The California Medical Association has been a pioneer and leader in the development of voluntary health insurance; and

WHEREAS, Purchasers of health insurance now need to have greater certainty of the adequacy of their coverage for the costs of doctors' services; and

WHEREAS, This greater certainty of coverage cannot be achieved without further positive action on the part of the medical profession; now, therefore, be it

Resolved, That the California Medical Association pledges every contribution it can make and in the public interest should make, to the fulfillment of this public need.

VICE-SPEAKER BAILEY: That goes also to Reference Committee No. 3.

DR. SHIPMAN: And the next three are the resolutions described by Dr. Magoon in the order in which they were passed by the Council. The first:

RESOLUTION No. 3

Resolved, That the California Medical Association proceed with vigor in the study, development and implementation of the Usual Fee Indemnity Plan.

VICE-SPEAKER BAILEY: Thank you. The same committee.

DR. SHIPMAN: And next:

RESOLUTION No. 4

WHEREAS, Many people are anxious to know in advance what their attending doctors' fees will be in order that they may secure adequate insurance or other means to pay those fees without worry about the financial problem at the time they need medical care; and

WHEREAS, Nearly all doctors already have fees which are their customary charges for the particular service involved; now, therefore, be it

Resolved, That the California Medical Association urge each of its members (a) To set up a list of his own fees, (b) to make this list known to his own patients, and (c) to assure his patients that he will make no higher charges except by agreement with the patient concerned before service is given.

VICE-SPEAKER BAILEY: That also goes to Reference Committee No. 3.

DR. SHIPMAN: And the third:

RESOLUTION No. 5

WHEREAS, Many physicians in the state of California, and many component medical societies have felt a desire to provide service benefits with greater certainty of coverage for subscriber groups within their own areas; and

WHEREAS, They have suggested that this should be done by the raising of the "income ceiling" in C.P.S. operations; and

WHEREAS, This House of Delegates has already gone on record as recommending experimentation in this field on the county society level with a view to ultimate development of improved forms of medical care insurance based on demonstrated experience and results; therefore, be it

Resolved, That this House of Delegates recommend:

1. That the California Physicians' Service develop a form of service coverage based on a \$6,000 income ceiling, with appropriate increases in the dues structure and in the schedule of fees to be paid, and in the formulation of a uniform schedule of fees;

2. That each county society be authorized to request that this form of C.P.S. coverage be offered within its own area, in addition to the present contracts;

3. That physician members of C.P.S. in a county which has not requested the higher ceiling, abide by the income ceiling (in providing full services without additional charge) for beneficiaries who have secured this coverage in some other county medical society area.

VICE-SPEAKER BAILEY: This goes to the C.P.S. Reference Committee.

DR. SHIPMAN: And the final resolution:

RESOLUTION No. 6

WHEREAS, The Medical Services Commission is making a continuing study of the economics of medical practice, and acts as an advisory committee to the Council of the California Medical Association; and

WHEREAS, The recommendations made to the Council of the California Medical Association by the Medical Services Commission are of vital importance to both rural and urban members of the California Medical Association, whether general practitioner or specialist; now, therefore, be it

Resolved, That the number of members of the Medical Services Commission be increased from nine to twelve.

VICE-SPEAKER BAILEY: This also goes to Reference Committee No. 3.

Dr. Ludwig—may I recognize—The Chair will recognize you next. Are there any announcements at this time?

... Announcements. ...

VICE-SPEAKER BAILEY: Now, Dr. Ludwig.

DR. LUDWIG: Mr. Speaker, I have two resolutions. The first is on foreign trained physicians for licensure:

RESOLUTION No. 7

WHEREAS, Each state in this country has its own licensing board with its individual licensing privileges there is no common denominator that will give a true comparative evaluation of the basic science background and professional competence of foreign trained physicians for licensure; and

WHEREAS, The Councils of Medical Education and Hospitals of the A.M.A. and the Association of American Medical Colleges list as acceptable for approval but a few of the over 500 foreign medical schools of the world and find that a conscientious evaluation of medical schools on a world-wide basis presents difficulties that are practically insurmountable; and

WHEREAS, A uniform procedure for screening the basic knowledge and professional competence of foreign trained physicians individually, completely dissociated from licensing privileges, will render a far greater service to the state medical licensing boards than the combined efforts of the Councils can render through attempts to evaluate foreign medical schools; and

WHEREAS, The National Board of Medical Examiners being set up to conduct high quality examinations in keeping with the current advances of medicine present a highly effective and uniform screening device; therefore, be it

Resolved, That the California Medical Association recommend to the Board of Medical Examiners of the Department of Professional and Vocational Standards that a mutually satisfactory method of procedure be developed with the National Board of Medical Examiners for the purpose of screening all foreign trained physicians; and be it further

Resolved, That the California Medical Association recommend to the Board of Medical Examiners that foreign trained physicians present evidence of having satisfactorily completed the National Board examinations as a prerequisite to consideration for licensure.

VICE-SPEAKER BAILEY: Thank you, Dr. Ludwig. That goes to Reference Committee No. 3.

DR. LUDWIG: The subject of this resolution is foreign trained physicians and quality of medical care:

RESOLUTION No. 8

WHEREAS, It is the present policy of the United States Government to admit into this country sev-

eral hundred thousands of displaced persons from all over the world and from many areas that have not had an immigration quota and included are a large number of foreign trained physicians about whose ability little is known; and

WHEREAS, Most foreign medical schools have not provided and currently cannot provide the pattern of medical education that is regarded everywhere in this country as minimal and foreign graduates in most instances have had no real training in the basic sciences or the clinical instruction so necessary in our concept of the proper training of the physician; and

WHEREAS, If large numbers of these foreign trained physicians without proper basic professional education enter into the practice of medicine in the United States it inevitably will lower the level of medical practice in this country for the next several decades; and

WHEREAS, The United States, for its own welfare must maintain the highest quality of medical practice in all its phases in order to provide the American people with what they now have, medical care not excelled anywhere in the world; therefore, be it

Resolved, That the California Medical Association instruct its Delegates to the American Medical Association to introduce and press for adoption a resolution directing the Council on Medical Education and Hospitals of the A.M.A. to withhold approval of any institution that accepts for intern or resident training foreign trained physicians who are ineligible for licensure in the United States, except those bona fide foreign graduates selected for training in this country and who return at the termination of said training.

VICE-SPEAKER BAILEY: Thank you, Dr. Ludwig. That will be referred to Reference Committee No. 3.

Dr. Sherman of San Francisco.

DR. SHERMAN: Mr. Speaker, these four following resolutions originated in and have the complete approval of the San Francisco Medical Society delegation to the C.M.A. The first resolution:

RESOLUTION No. 9

WHEREAS, The California Physicians' Service has now established two different methods for prepaid care of the sick, namely, service type plan and an indemnification plan; and

WHEREAS, These two types differ in structure, organization, required reserve and are under different jurisdiction, namely (1) service type—attorney general, and (2) indemnity type—insurance commissioner; and

WHEREAS, Under the above conditions, the financial structure must of necessity be separate and distinct; therefore, be it

Resolved, That the financial contribution of the service plan to the indemnity plan be limited to the very minimum necessary to assure performance of contracts entered into; and

Second, That the directors of the indemnity corporation conduct its business in a conservative manner.

VICE-SPEAKER BAILEY: That will go to Reference Committee No. 3.

DR. SHERMAN:

RESOLUTION No. 10

WHEREAS, The California Physicians' Service is now well established, financially sound and able to meet its obligations; therefore, be it

Resolved, That the California Physicians' Service Trustees carry only the average reserve recommended by the National Association of Insurance Commissioners in order that the full amount of an adequate fee schedule can be paid.

VICE-SPEAKER BAILEY: That will go to the C.P.S. Reference Committee.

DR. SHERMAN:

RESOLUTION No. 11

WHEREAS, There has been a continuing and recurring pressure to raise the income ceiling in California Physicians' Service since its inception;

WHEREAS, The fee schedule has not been raised in proportion;

WHEREAS, The recent proposal to raise the income ceiling to \$6,000 gross family income will encompass a large majority of those eligible for voluntary health insurance; therefore, be it

Resolved, That when so large a proportion of the population may be covered, the fee schedule should be reasonable, which means in fact the prevailing private fees; until the California Medical Association has developed an acceptable schedule for the state, such interim fee schedules should be those developed by the county medical associations in which they apply and when it is locally desired and should include a provision for major medical illnesses as well as surgical conditions; review and revision of all schedules in force should be yearly; and be it further

Resolved, That it be established as a principle that whenever the income ceiling is raised that there be a concomitant and equitable adjustment of the fee schedule.

VICE-SPEAKER BAILEY: We will refer that to the C.P.S. Reference Committee.

DR. SHERMAN: The last is very short.

RESOLUTION No. 12

Resolved, That if the \$6,000 gross family annual income ceiling is adopted by the California Medical Association House of Delegates with its accompanying increased fee schedule, California Physicians' Service may be permitted to write policies for lower income ceilings provided that there be concomitant and equitable increases in the California Physicians' Service fee schedule for these groups.

VICE-SPEAKER BAILEY: Again this goes to the C.P.S. Reference Committee.

DR. GARNETT CHENEY (San Francisco): This is Garnett Cheney of San Francisco. I have only one resolution to introduce:

RESOLUTION No. 13

WHEREAS, Those physicians restricting their practices to nonsurgical illnesses have for many years taken part in prepay sickness insurance programs largely as a public service; and

WHEREAS, With the extension of prepay insurance plans the economic position of the nonsurgical physician is rapidly becoming untenable; and

WHEREAS, The satisfaction of all physicians, whether surgical or nonsurgical, is essential for the ultimate success of prepay sickness insurance; and

WHEREAS, Major medical illness is comparable to major surgical illness in its justification of an adequate fee; therefore, be it

Resolved, That the following principles be accepted:

1. Each physician rendering service as a C.P.S. professional member shall be requested to declare himself as to his field of practice, whether surgical or nonsurgical.

2. A nonsurgeon member shall be a physician who derives 5 per cent or less of his professional income from surgical procedures.

3. The present fee schedule of C.P.S. is to be elaborated to include a detailed schedule of diagnosis and treatment of major medical illnesses.

4. Physicians practicing as nonsurgeons shall be prepared to make available upon request a suitable case report to the medical director of C.P.S.

VICE-SPEAKER BAILEY: Thank you. That goes to C.P.S. Reference Committee.

Dr. Herzog.

DR. HERZOG: Dr. George K. Herzog, San Francisco.

I have but one resolution. It has been presented to the San Francisco Delegates and approved by them.

RESOLUTION No. 14

WHEREAS, Under the California adoption laws independent adoptions are permitted, under which a mother is allowed to place her child for adoption; and

WHEREAS, Physicians and attorneys representing mothers who desire to place their children for adoption have in good faith, and in reliance on their respective licenses to practice, furnished medical and legal advice and assistance; and

WHEREAS, A recent opinion issued by the Attorney General of the State of California casts doubt on the right of a mother placing a child for adoption to have legal counsel and medical advice; and

WHEREAS, It is believed to be contrary to the public interest to restrict the right of any citizen to medical aid and assistance and legal counsel; now therefore, be it

Resolved, That the House of Delegates of the California Medical Association urges the Legislature of the State of California to clarify the adoption laws by adding a section thereto specifying that the parent of a child has the right, in presenting the child for adoption, to act through her attorney or her physician, or both, and to have legal counsel and medical assistance, in this field as in all others; and be it further

Resolved, That a copy of this resolution be forwarded by the secretary of the Association to the State Bar of California, with the request that the appropriate legislative body of the State Bar approve the principles herein expressed and authorize the State Bar to join with the California Medical Association in bringing this matter to the attention of the Legislature.

VICE-SPEAKER BAILEY: Thank you, Doctor. That will go to Reference Committee No. 3.

DR. FLOOD: Randolph G. Flood, San Francisco.

Ladies and Gentlemen: I have one resolution that I would like to present.

RESOLUTION No. 15

Resolved, That if the \$6,000 gross family annual income ceiling is adopted by the C.M.A. House of Delegates with its accompanying increased fee schedule, that this income ceiling level and its fee schedule be considered the only ones in existence on the expiration of all present C.P.S. policies.

VICE-SPEAKER BAILEY: That will go to the C.P.S. Committee, Doctor.

DR. TALBOTT: Grace Talbott of San Francisco.

VICE-SPEAKER BAILEY: We are going to have somebody besides someone from San Francisco next time.

DR. TALBOTT: This is a resolution that was presented to the San Francisco County Medical Society and accepted by them unanimously.

RESOLUTION No. 16

WHEREAS, The Council on Medical Education and Hospitals of the A.M.A. appears to be developing a policy of eliminating partial residencies from accreditation in those hospitals where complete board training is not offered, as shown by the recent ruling withdrawing approval of one year pediatric residencies; and

WHEREAS, Restriction of recognition of residencies only to those institutions who can furnish a complete program of two or more years as recommended by the Council on Medical Education and Hospitals of the American Medical Association militates against the adequate training of residency staffs and the perfection of care of patients, both clinic and private, in many hospitals, with or without university affiliations; therefore, be it

Resolved, That representation should be made to the A.M.A. House of Delegates calling to their attention the opinion of the C.M.A. House of Delegates as to the deleterious effects on hospital programs of

the above action of the A.M.A. Council on Medical Education and Hospitals.

VICE-SPEAKER BAILEY: Thank you very much. It will go to Reference Committee No. 3.

Now we will have Dr. Ed Crane from Los Angeles.

DR. CRANE: This resolution represents the feeling of the Inglewood branch of the Los Angeles County Medical Association. It is somewhat a duplicate of a previous resolution that has just been presented but we felt it might add something to the previous resolution and help the committee come to a better solution.

RESOLUTION No. 17

WHEREAS, C.P.S. fee schedule has been admittedly a low fee schedule since its start;

WHEREAS, The majority of medical doctors of C.M.A. are agreed on this point;

WHEREAS, This fee schedule is widely publicized and used as index of what C.M.A. doctors consider adequate medical fees; and

WHEREAS, This schedule is being used as a yardstick by commercial insurance companies;

WHEREAS, This basic fee schedule has not been appreciably changed since its inception in 1939; now, therefore, be it

Resolved, That the House of Delegates instruct the directors of C.P.S. to set up a fee schedule which is 75 per cent higher than the original 1939 fee schedule; and be it further

Resolved, That the directors of C.P.S. be instructed that they may pay that per cent of this fee schedule that is consistent with a solvent operation; and be it further

Resolved, That the Directors of C.P.S. review this schedule each year for question of alteration.

VICE-SPEAKER BAILEY: Thank you, Dr. Crane. That will go to the C.P.S. Reference Committee.

Dr. Bullock.

DR. BULLOCK: Lewis T. Bullock, Los Angeles County Medical Association.

RESOLUTION No. 18

WHEREAS, Rabies is a communicable disease transmitted to man largely through the bite of dogs. It is always fatal. No useful treatment is known but a reliable means of prevention is available through the use of a safe and effective vaccine grown on eggs. This vaccine is safer, cheaper and less painful than the old Pasteur treatment for prevention after exposure. Rabies can be eliminated. Continued deaths of animals or of humans result from failure to apply available knowledge; now therefore, be it

Resolved, That this House state its support of universal vaccinations of dogs against rabies as a valuable measure for the protection of the public health and that a bill to require vaccination of all dogs in California against rabies be prepared, introduced and supported in the Legislature by the representatives of the California Medical Association.

VICE-SPEAKER BAILEY: That will go to Reference Committee No. 3.

Dr. Henry Gibbons of San Francisco.

DR. GIBBONS: Dr. Gibbons, San Francisco.

RESOLUTION No. 19

WHEREAS, The maintenance of good health care is a prime function of the medical profession, and is essential for the success of voluntary sickness service plans; and

WHEREAS, Adequate availability of service by medical and surgical specialists is an integral part of good health care; now, therefore, be it

Resolved, That this House of Delegates request the officers of C.P.S. to study and recommend means for the inclusion of specialist services in the benefits of its insurance policies.

VICE-SPEAKER BAILEY: Thank you. That will go to C.P.S. Reference Committee.

Dr. Newhall.

DR. NEWHALL: Dr. Newhall from Santa Cruz. This resolution has been approved by the Santa Cruz County Medical Society.

RESOLUTION No. 20

WHEREAS, The public is entitled to efficient and harmonious operation of a nonprofit hospital; and

WHEREAS, The primary responsibility of the hospital management is to provide facilities and the primary responsibility of the medical staff is to provide medical care; and

WHEREAS, Even though close cooperation and many overlapping functions are involved in the provision of good care to hospitalized persons, the separate underlying responsibilities provide a natural basis for a healthy balance of power; therefore, be it

Resolved, That the California Medical Association go on record in favor of the proposition that the duly constituted medical staff of a nonprofit hospital be allowed to make the final decisions regarding acceptance and rejection of its members; and be it further

Resolved, That this resolution be brought to the attention of hospital accrediting agencies for use by them as they review the organizational structure of nonprofit hospitals in the State of California.

VICE-SPEAKER BAILEY: Thank you, Doctor. That goes to Reference Committee No. 3.

Dr. Martin.

DR. MARTIN: James Martin, San Bernardino County. Mr. Speaker:

RESOLUTION No. 21

WHEREAS, The American Medical Association in holding its annual sessions finds that it is necessary for these meetings to be held at various centers in the United States; and

WHEREAS, These meetings are held every few years in California; and

WHEREAS, There are but few suitable locations for these meetings in California; and

WHEREAS, These meetings entail considerable expense by the local medical society, which usually acts as the host; and

WHEREAS, This expense is thus not fairly distributed, and financial aid from other county medical societies is usually not obtained; now, therefore, be it

Resolved, That the California Medical Association meet such expenses and thus provide a more equitable distribution of the costs.

(Applause.)

VICE-SPEAKER BAILEY: Thank you. That will go to Reference Committee No. 3.

Now may we have Dr. Davis.

DR. DAVIS: I won't hold you in suspense any longer. The title of the first resolution is "Definition of a Crippled Child." (Laughter.)

RESOLUTION No. 22

WHEREAS, There has been great dissatisfaction with the existing definition of a crippled child, as defined in the Crippled Children's Act; and

WHEREAS, This dissatisfaction has not been confined to the medical profession, but also was emphasized by the Assembly Interim Committee on Public Health in its report of January 16, 1953, regarding the Crippled Children's program in California; now, therefore, be it

Resolved, That the Council of the California Medical Association and the appropriate committees be instructed by this House of Delegates to exercise their good judgment toward efforts to amend the existing definition to make it more satisfactory; and, furthermore, be it

Resolved, That the following definition is suggested: "For the purposes of this act a physically handicapped child is any person under twenty-one years of age who has a physical defect resulting from congenital anomaly or acquired through disease, accident, or faulty development; and for which treatment is required in order to assure the child more normal mental and physical development or to arrest the extension of the handicap.

"Treatment may be afforded when there is reason to believe that such treatment may cure or arrest the condition and when financial hardship prevents adequate care through other than public means, or where adequate care can not be obtained through the usual channels. It is the purpose of the Act to provide assistance to handicapped children who may be benefited but the Act is not to be interpreted in a manner which will dissipate these funds for purposes in which:

"1. There is not reasonable assurance of physical improvement in the child.

"2. Where other funds are available to meet the cost of such care.

"3. Where the condition is of a trivial nature.

"4. Where the care may safely be postponed until such time as the child may elect to have the treatment himself."

VICE-SPEAKER BAILEY: That will go to Reference Committee No. 3. We have another one, Dr. Davis.

DR. DAVIS: This second resolution is entitled "Hospital Accreditation."

RESOLUTION No. 23

WHEREAS, Before 1953, the American Medical Association did not take an active part in the overall examination and approval of hospitals and similar institutions limiting its approval to the particular services in these institutions, which were satisfactory for intern and resident training; and

WHEREAS, Approval of the general operating facilities of a hospital including sanitation, medical staff, and administrative policy had prior to 1953 been subject to various inspections by different organizations and this led to confusion regarding the relative merits of these approvals; and

WHEREAS, On December 6, 1952, the Hospital Standardization Program of the American College of Surgeons was officially conveyed to the Joint Commission on Accreditation of Hospitals, which is composed of representatives of the American Medical Association, the American Hospital Association, the Canadian Medical Association, the American College of Physicians and the American College of Surgeons; and

WHEREAS, This group during 1953 established standards for Hospital Accreditation; and

WHEREAS, Some of these standards relating to medical staff are as follows:

1. The medical staff is responsible for the quality of medical care in the hospital and must accept and assume this responsibility, subject to the ultimate authority of the hospital governing body.
2. The medical staff must be a self-governing body.
3. Staff meetings are held for the purpose of reviewing the medical care of patients within the hospital and not for the presentation of scientific papers or discussions.
4. Staff appointments are made officially by the governing body. Recommendations are customarily made by the active staff, and in no case shall a governing body make an appointment to the staff without first requesting such a recommendation.
5. Officers shall come from the active staff and shall be elected by the active staff; now, therefore, be it

Resolved, That this House of Delegates of the California Medical Association endorses the concept that hospital accreditation is of interest to all practitioners under which the Joint Commission on Accreditation of Hospitals was formed and endorses the Standards of Hospital Accreditation as published by the Joint Commission on Accreditation, a portion of which is listed above; and be it further

Resolved, That all component county medical societies be made fully aware of this new acceptable

mechanism which is designed for furthering the public health and welfare; and be it further

Resolved, That this House of Delegates of the California Medical Association encourages the component county medical societies to advise their members that members of the societies and of this association be encouraged to assist those institutions which are not able to meet these standards in order that they may qualify for such accreditation.

VICE-SPEAKER BAILEY: Thank you, Dr. Davis. That goes to Reference Committee No. 3.

Dr. Hadley, do you have something to offer there?

DR. HADLEY: Dr. Hadley of San Bernardino. Mr. Speaker, this resolution was discussed by our local county medical society and I wish we all would remember that we are none of us actuaries but are in full accord with the principles of this resolution.

RESOLUTION No. 24

WHEREAS, California Physicians' Service was conceived and developed to provide medical and surgical care for those people in the semi-indigent or low income bracket; and

WHEREAS, These people have now achieved a higher income status, and are most desirous of being protected against the higher cost of the more serious illnesses, and who look upon fee schedules according to their top limits; and

WHEREAS, The care for ordinary and minor ailments is a part of their daily economy, that they can individually pay for; and

WHEREAS, Thus California Physicians' Service in its present form has developed into a new field for which there is no coverage; therefore, be it

Resolved, That the present system of affording medical and surgical care by California Physicians' Service shall be abolished and a new concept of such care be established in the form of a \$50 annual deductible type of insurance in which the individual family shall pay the first \$50 per year for any medical and surgical expense, and the California Physicians' Service shall pay for the remainder to the limit of five years' care or \$5,000.

VICE-SPEAKER BAILEY: Thank you, Dr. Hadley. Since you are chairman of Reference Committee No. 3 I take it you would recommend sending this to C.P.S. Reference Committee? So be it. C.P.S. Reference Committee for Dr. Hadley's resolution. Dr. Bender.

DR. BENDER (San Francisco): Mr. Speaker, members of the House: I have three but they are not terribly long. First is:

RESOLUTION No. 25

WHEREAS, During the past three years, the American College of Surgeons has conducted in the public press a sensational campaign of accusation and condemnation of alleged widespread practice of fee-splitting, ghost surgery and unnecessary operations on the part of the medical profession; and

WHEREAS, Such criticism has been wholly destructive and unaccompanied by any effective remedy to supplement public exposure; and

WHEREAS, There exists within the representative organizations of the medical profession means to eradicate the practices so vigorously condemned; therefore, be it

Resolved, That the accompanying letter, which develops the method by which such undesirable practices can be eradicated by the medical profession, be sent to the Board of Regents of the American College of Surgeons, with copies to the governing bodies of the American College of Physicians, American Hospital Association, and the Canadian Medical Association, with the assurance of the wholehearted and active support of the California Medical Association in such a constructive effort, in the interest of the public and of the overwhelming majority of physicians whose integrity is beyond question.

Mr. Chairman, this letter is necessarily long and I respectfully suggest that it not be read at this time because it is going to be typed and members will have a chance to read it.

VICE-SPEAKER BAILEY: Thank you. Your suggestion is accepted. That will go to Reference Committee No. 3.

(The following is the letter referred to by Dr. Bender):

American College of Surgeons
40 East Erie Street
Chicago 11, Illinois
Gentlemen:

Time after time in the past three years the American College of Surgeons has broadcast to the public that fee-splitting, ghost surgery and unnecessary operations are widespread practices. There is reason for disagreement with such an indictment, but it is not the purpose of this letter to argue the validity of your charges. Rather would we implement effective means of correction. Certainly elimination of such acts is mandatory if we are to serve the best interests of the public and preserve the fair name of medicine which we hold in trust from our forebears for our successors.

These unsavory practices can be eradicated. The American College of Surgeons has taken the first steps; the College is duty-bound to take the final one, for which you have the machinery already in motion. We feel it is our duty to suggest methods by which this can be done on both national and local levels.

For many years, the American College of Surgeons has developed and maintained standards of hospital operation with a nationwide system of inspection of facilities, records and operational procedures. In order to be accredited, an institution must meet certain requirements. Most hospitals strive for such approval; to lose it would be catastrophic. In December 1952, the American College of Physicians, the American College of Surgeons, the American Hospital Association, the American

Medical Association and the Canadian Medical Association joined to strengthen the project, which is conducted now by the Joint Commission on the Accreditation of Hospitals. Thus inspection of hospitals is an established accepted procedure.

Fee-splitting, ghost surgery and unnecessary operations are surgical offenses. Practically all operations are performed in hospitals. The Joint Commission on Accreditation has the power to withdraw certification and to penalize severely any institution which condones such practices. To eradicate alleged abuses, we feel that certain of your principles should be more rigidly enforced and others added. Among these we might mention the following:

1. Definite specific rules which will outlaw such misconduct.

2. Notify accredited hospitals, and those who apply, that infraction of these rules will cancel your approval automatically. Make hospitals responsible for misdeeds of staff physicians, in fact of all professional personnel.

3. Raise the standards of hospital records, particularly the detailed description of each operation and of the microscopic examination of tissue removed.

4. Augment your inspection service with inspectors qualified to evaluate critically such records, and to report their findings factually, including their own microscopic examination of tissue in questionable cases.

5. Make expulsion the automatic punishment of any of your members found guilty of such misconduct.

6. One of your rules may have to require each physician taking part in a surgical case to send his bill separately. Disregard of this principle should subject the hospital in which the patient was cared for to cancellation of certification. Strong medicine, even autocratic, but absolutely justifiable if necessary to root out the evil we fight.

7. With the same zeal with which you condemn misconduct, publicize what you are doing to correct it, including names of hospitals which are added to or deleted from the approved list, as a measure of their cooperation in the drive for surgery of integrity.

The third step will detect the ghost surgeon. The fourth will expose the unnecessary operator. The sixth may be necessary to probe any fee splitting arrangements but we have the feeling that the stimulated cooperation of other members of the same staff will help solve this problem. A hospital faced with loss of certification will expel the causative culprit from its staff, in self protection, at least. Without the hospital to work in, where will he be able to continue his waywardness? Only in hospitals of uncertain standards and it won't take patients and other doctors long to avoid these. We physicians are opposed fundamentally to regimentation, but we must distinguish between this and self-discipline. The peri-

odic visit of a bank examiner does not disturb the bank with its affairs in good order.

Of course, such an expanded inspection and publicity program would be costly, but what price integrity? Untold effort and countless dollars are expended on public relations which go up in smoke before one of your blasts. Let's use some of these resources to eradicate the evil. What better public relations?

At the local level much can be done to supplement your effort. Most county societies have an active committee on professional relations which hears and adjudicates charges from patients or physicians of improper conduct by any of their members, and has the power to impose punishment. They would welcome the opportunity to join your crusade, given the impetus of constructive action by the Joint Commission on the Accreditation of Hospitals. We urge you to use your influence toward this end. There will be a continuing effort to stimulate both patients and physicians to expose such malfeasance.

You have stated our house needs cleaning. That is a job for us, not for our neighbors, the public we serve. We assure you of our wholehearted cooperation in carrying out any plans which you may institute. Any public condemnation of fee-splitting, ghost surgery and unnecessary operations in the future must logically devote at least equal space and emphasis to an organized campaign by the medical profession to eradicate such practices.

Yours very truly,

California Medical Association
By the President

DR. BENDER:

RESOLUTION No. 26

WHEREAS, The medical profession of California is being called on to practice under increasing numbers of health insurance plans, physician-sponsored and otherwise, with great diversity of operative provisions; and

WHEREAS, The subject is to be complicated further by the projected three-fold program of C.P.S., i.e., the existing service plan, the proposed local-option higher-ceiling program, and the authorized but not yet operative indemnification method; and

WHEREAS, No provision exists within C.M.A. solely and specifically for state-wide integration of the activities of constituent county societies relative to all such health insurance plans, since the function of the C.P.S. Board of Trustees is administrative and limited in its scope to C.P.S. projects, and the C.M.A. Council has many other unrelated responsibilities; and

WHEREAS, The competitive predominance of unregimented medicine and surgery will depend inevitably on the considered uniformity of policy and action of free doctors of medicine; therefore, be it

Resolved, That an authority be created in an existent committee, if practicable, or in a special committee composed of seven individuals, appointed by the Council and of course responsible to the Council, to serve strictly as an action committee, in contra-

distinction to study groups, for the specific purpose, to

1. Develop and implement strategy, immediate and long-range, designed to make the private individualized practice of medicine more and more attractive competitively, with at least equal emphasis on quality of medical care, which is our area of strength, as on cost;

2. Coordinate as closely as possible the activities in this field by constituent county societies, without presuming to invade the autonomy of those societies, in the interest of the economy, efficiency and effectiveness which are characteristic of uniformity of effort;

3. Integrate and intensify the publicity activities of C.M.A. and C.P.S. in health insurance matters, in order to inform the physicians of California of our task as individuals and as an organization, and about the issue; and to impress on the whole population the facts about sound medical care and its cost;

4. In short, to combine the experience of the past fifteen years, and the product of continuing studies, with ideation and planned action, to win back for the medical profession the initiative essential to perpetuation of the time-proven individualized practice of medicine.

VICE-SPEAKER BAILEY: Thank you, Dr. Bender. That will go to the C.P.S. Reference Committee.

DR. BENDER:

RESOLUTION No. 27

WHEREAS, C.M.A. and C.P.S. pay on a per diem basis for the maintenance of those serving those organizations away from their homes, that is \$25 per diem to officers, C.M.A. Councilors, Delegates and Alternates to A.M.A., and C.P.S. Trustees as compared with reimbursement for actual living expenses of committee members and employees traveling on official business; and

WHEREAS, The \$25 per diem allotment is actually greater than the maintenance allocation of comparable organizations including the great majority of other state medical associations; and

WHEREAS, The increasing need of funds for the task of strengthening the competitive position of unregimented medicine in the complicated and expanding field of prepaid medical care and for other responsibilities justifies reasonable conservation of our resources in the internal operations of C.M.A. and C.P.S.; therefore, be it

Resolved, That the \$25 per diem allotment be discontinued and replaced by reimbursement for actual cost of first class hotel accommodations of members equitably to all C.M.A. members serving in official capacity away from home; and be it further

Resolved, That the current comparable practice of paying the actual cost of the first class travel for such representatives be continued.

VICE-SPEAKER BAILEY: That goes to Reference Committee No. 2 since it has to do with finances.

DR. MILES (Monterey County): Mr. Speaker:

RESOLUTION No. 28

WHEREAS, It has become apparent that the sale to chiropractors and other unauthorized users of certain drugs and pharmaceuticals, particularly barbiturates, antibiotics and sulfonamide drugs, has become a practice with certain drug houses; and

WHEREAS, Certain chiropractors and other unauthorized persons are said to be dispensing these drugs illegally and without control in violation of existing statutes and laws; now, therefore, be it

Resolved, That the House of Delegates of the C.M.A. direct the Council of the C.M.A. to urge the California State Board of Pharmacy and other state and federal agencies concerned to investigate these violations and to more rigidly enforce these laws now existing and prohibiting such sale and use by unauthorized practitioners; and be it further

Resolved, That a copy of this be sent to the California State Board of Pharmacy.

VICE-SPEAKER BAILEY: Thank you, Dr. Miles. Are there any further resolutions?

DR. MILES: I have one.

VICE-SPEAKER BAILEY: Yes, Dr. Miles, one more.

DR. MILES: This resolution is presented with the approval of the Executive Committee and membership of the State Society of Pathologists:

RESOLUTION No. 29

WHEREAS, The Clinical Laboratory Act as now in effect recognizes three classes of lay individuals subject to licensure or certification, namely, the clinical laboratory technologists, technicians and technician trainees; and

WHEREAS, The Clinical Laboratory Act recognizes as directors of clinical pathological laboratories not only doctors of medicine but lay individuals not holding the degree of Doctor of Medicine, but known as technologists; and

WHEREAS, The Clinical Laboratory Act is at variance with actions taken by the House of Delegates of the American Medical Association and the House of Delegates of the California Medical Association which have repeatedly reaffirmed that pathology in all its branches is the practice of medicine; and

WHEREAS, The State of California, Department of Public Health, currently has under consideration a proposal to seek amendment to the Clinical Laboratory Act which would widen licensure or certification of any M.D. individuals at the technologist level, such licensure to permit biochemists, microbiologists and others to direct laboratories in which only tests within their specialized fields would be conducted; and, further

WHEREAS, This proposed extension of licensure or certification would make eligible as candidates for certification those additional individuals holding the degree of Doctor of Philosophy with two years' acceptable experience; and

WHEREAS, Any enlargement of the licensure of individuals not holding the degree of Doctor of

Medicine under the Clinical Laboratory Act to practice this duly recognized branch of medicine is not in the public interest or good as well as at variance with the principles adopted by the American Medical Association and the California Medical Association; be it therefore

Resolved, That

1. The House of Delegates of the California Medical Association direct the Council of the California Medical Association to inform the State of California Department of Public Health that it is not in favor of any proposed legislation which would further enlarge the licensing or certification criteria of the Clinical Laboratory Act.

2. That the Council of the California Medical Association take such steps as are necessary to oppose any such legislation.

3. That a copy of this resolution be forwarded to the Director, State of California, Department of Public Health.

VICE-SPEAKER BAILEY: Thank you, Dr. Miles. Are there further resolutions? That goes to Reference Committee No. 3.

DR. RODERICK OGDEN (Kern County): This resolution was presented to and approved by a meeting of a number of delegates from the San Joaquin Valley at the interim hearing in December:

RESOLUTION No. 30

WHEREAS, The American Medical Association and the California Medical Association have extended considerable effort to establish favorable public relations between medical students and organized medicine; and

WHEREAS, The cost of medical education, in tuition, fees and subsistence, has increased to such a degree that a number of students who offer promise of being excellent physicians are either denied that opportunity or greatly hindered in its fulfillment; and

WHEREAS, Concrete evidence of the interest of organized medicine in the problems of medical students, particularly in the rendering of financial aid, would undoubtedly be a very strong factor in establishing good relations between students in training and organized medicine, and would also allow some students, who in later years would reflect credit and honor on medicine, to complete their education; therefore, be it

Resolved, That the Council of the California Medical Association investigate, or appoint a committee to investigate, the possibility of establishing a large and liberally administered Student Loan Fund, and if feasible establish such a fund.

VICE-SPEAKER BAILEY: That goes to Reference Committee No. 3, Dr. Ogden. Thank you. Any further resolutions?

We might say that the San Francisco delegation has changed its time from today to 8:00 a.m. Mon-

day, and then there are several who propose to meet at 5:00 o'clock; I suppose will meet as soon as possible.

... Announcements. ...

... Speaker Charnock assumed the Chair. ...

SPEAKER CHARNOCK: You are, of course, all aware that the Reference Committees are going to meet as designated on the blackboard. Those delegates who wish to appear before the reference committees may do so. These committee hearings are open only to delegates and to alternates. The reference committees may call for such technical help as they need. Is there any more new business to come before this organization?

Dr. Lum has an announcement.

DR. LUM: Mr. Speaker and House of Delegates: There will be copies available at the front desk of the budget for your study. There is one correction to be made. One item was inadvertently omitted. Under Organizational Expense the item now proposed at \$5,000 should be made \$188,000. (Laughter.)

SPEAKER CHARNOCK: Will Reference Committee No. 2 be so informed. Of course they are.

DR. TRUMAN: Mr. Speaker, you announced that the reference committees were open only to delegates and alternates. I believe that this has never been so before and I would like to ask you if this is a new policy or if you have changed the policy or if you are in error.

SPEAKER CHARNOCK: I am taking that on advice of legal counsel. The understanding is that the reference committees are executive sessions and that only the delegates and the alternates go to them.

Dr. Bullock.

DR. BULLOCK: Mr. Chairman, I would like to move that the reference committees be open to all members of the C.M.A.

A DELEGATE: Second the motion.

SPEAKER CHARNOCK: I did not hear you, Dr. Bullock.

DR. BULLOCK: I would like to move that the reference committees be open to all members of the C.M.A.

SPEAKER CHARNOCK: It has been moved and seconded that the reference committees be open to all members of the California Medical Association. Is there any discussion? The Chair hearing none, those in favor of this motion will signify by saying "aye." To the contrary?

... There being no discussion, the motion was put to a vote and it was carried. ...

SPEAKER CHARNOCK: Will the "noes" again vote?

The motion is passed. I might say by way of explanation (laughter)—we had expected the C.P.S. Reference Committee to meet in this room immediately and it was a matter of having them in executive session without going through a nose-counting.

I will entertain a motion to adjourn until 9:30 a.m. Wednesday, May 12, in this room.

A DELEGATE: So moved.

A DELEGATE: Second.

SPEAKER CHARNOCK: It is moved and seconded we adjourn. Those in favor will signify by saying "aye." To the contrary?

... The motion was put to a vote and unanimously carried. ...

SPEAKER CHARNOCK: It is passed.

... The meeting adjourned at 5:20 p.m. ...

Wednesday Morning Session

The Wednesday morning session of the House of Delegates of the California Medical Association was held in the Renaissance Room, Biltmore Hotel, Los Angeles, California. The meeting was called to order at 9:30 a.m. by the Speaker, Dr. Donald A. Charnock, who presided.

SPEAKER CHARNOCK: Will the House please be in order? We will have the supplemental report of the Credentials Committee. Dr. Armanino.

REPORT OF THE CREDENTIALS COMMITTEE

DR. LOUIS P. ARMANINO: Mr. Speaker, a quorum is present.

SPEAKER CHARNOCK: If there is no objection to the House accepting the visual roll call as to the constitution of the House—the Chair hearing none, it is accepted.

The first order of business will be the presentation by our President, Dr. Green. Dr. Molony.

PRESIDENT GREEN: Mr. Speaker, members of the House:

It just so happened that one of the illustrious doctors of the California Medical Association was unable to be present for the acceptance of a Fifty-Year pin for his services to you and to me. The name of the man is Dr. George H. Kress.

Almost everyone here is indebted in some fashion for the services of Dr. Kress. At the Interim Session that we held last winter it might have been in order to present this pin to George H. Kress while he was still living because as of January 1, 1954, he was eligible. But George said, "No, I can't receive it until I have paid the full measure of service."

So at this time your Council has decided that the award will be made to Mrs. Kress by means of Dr. William Molony, also a fifty-year man, and a very close associate and great friend of Dr. George Kress. So with your permission I will award this pin to Mrs. Kress in absentia through Dr. William Molony who will express to her something that I couldn't express. (Applause.)

... The award was presented by President Green. ...

SPEAKER CHARNOCK: During the presentation may I ask the House to rise in respect to Dr. Kress.

PRESIDENT GREEN: William, will you transmit this badge of honor to Mrs. Kress in the name of the California Medical Association?

DR. MOLONY: I will. May I say a word?

SPEAKER CHARNOCK: Yes.

DR. MOLONY: It is fifty years ago this year that I first met Dr. Kress. He came here a year or so after graduation. During these fifty years, and they were very busy and full years for him, he devoted himself constantly and unrelentingly to the interests of medicine in California.

I know no one in my experience, my life in the history of organized medicine in California, who did more for medicine than George Kress. During the hectic years of the beginnings of the organization of the statute books of California, when the chiropractic and osteopathic professions were adjudicated, George Kress was in the front and foremost in that battle. And to his energy, his ability and his brains came most of the ammunition that served to defeat these measures in 1916.

However, history proves that one battle doesn't always turn the course of events. However, regardless of all these things, as long as he lived, as Secretary of the Los Angeles County Medical Association, as Editor of the State Journal, Councilor of the California Medical Association, and as President of the California Medical Association, he was always in the forefront. He gave of his time and energy and his ability for the benefit of organized medicine.

It is a pleasure in one way and in another way it is a sad mission that I have to perform, taking this to Mrs. Kress. I am sure that she will appreciate the great consideration and honor you have paid to the memory of George Kress today, and I thank you very much. (Applause.)

SPEAKER CHARNOCK: Thank you, Dr. Molony. Thank you, Dr. Green. I am sure that this gesture by the House will be greatly appreciated by Mrs. Kress.

I think the House should be informed that the voluminous history on which Dr. Kress was working so hard at the time of his death is now being gathered together and collected and put into shape to be turned over to an appropriate committee.

At this time the next order of business is the Secretary's announcement of the Council's selection of the place for the 1955 Annual Convention. Dr. Daniels.

DR. DANIELS: Mr. Chairman: The Council has selected the dates of May 1 to May 5, 1955, as the dates of the next Annual Session. It is with some regret that we admit it will not be in Los Angeles. San Francisco has been selected and the Palace Hotel will be the headquarters.

SPEAKER CHARNOCK: Thank you, Dr. Daniels. I am sure we will all have a lot of fun. (Laughter.)

The next order of business is the election of officers. The first office to come before you is that of President-Elect. Dr. Sam Sherman of San Francisco.

DR. SHERMAN: Mr. Speaker, Fellow Delegates: If you in the assembled delegation have wondered why most of the San Francisco delegates have conducted themselves this year in a restrained, orderly and perhaps decorous manner (laughter) it is just that we feel the weight of a great responsibility on our consciences and our souls.

We this year have the distinct honor of offering to this convention a name of one of the most distinguished members of our medical society as a candidate to fill the office of President-Elect of the California Medical Association.

San Francisco in the past has contributed many great names to this particular office in the Medical Association. Those of you who have gray heads will probably remember such famous names as Howard Marlow, Morton Gibbons, Jr., and then Karl Schuapp, Sr., and as we go down the line we have other famous names such as Phil Gilman, and of course the last contribution from San Francisco, who has served with distinction as President of the California Medical Association and also as President of the American Medical Association, is none other than John Cline, whom you all know very well.

This year our task in San Francisco was to select a man whose stature was at least equal to that of his predecessors in this respect. Strange as it may seem, it was an easy task for us because we have in our ranks someone whose ability and whose fine qualities of leadership, whose fine gentlemanly qualities as well, have made him a perfect candidate. He, like some of his predecessors who have served as presidents of this organization, has also served his local society as well as his state society well and with great distinction.

He came to California in 1921 after graduating from the University of Michigan in 1919. And another strange coincidence has occurred; he first entered practice with the man who was honored at the beginning of this convention by being awarded a Fifty-Year pin. I refer to Dr. Robert A. Peers. After serving in practice with Dr. Peers he came to San Francisco and of course put himself vigorously into scientific as well as organizational work. He served the San Francisco Medical Society as a director for many years and also as its president and also chairman of many important committees.

He came to the Council of the C.M.A. in 1945 and exhibited such qualities of leadership that it was not long afterwards that he was made chairman of the Council and has served well since then.

He has also had the honor of being president of the National Tuberculosis Association in 1953. Besides this he has a hobby of which he is very proud. This hobby is that he likes to go out through the Golden Gate in San Francisco in a leaky old boat and try to catch salmon. And his wife reports to me that he usually only brings home a head cold and a dead motor. (Laughter.)

In spite of all this I have known this gentleman for almost a quarter of a century in a triple capacity. First I have known him as a teacher to me as a medical student at the University of California.

There he was kind, he was generous in his teaching, and he gave us as students a great deal of wise counsel. I have known him also in the capacity of a colleague in the practice of medicine and as a fine specialist in the treatment of pulmonary diseases to whom I was always proud and privileged to refer my cases of that nature. But lastly, I have known him as a fellow worker in organizational medicine, a man who I felt again exhibited all of the fine leadership qualities and all of the fine things that have acted as an inspiration to those of us who are much younger.

It is because of the untiring efforts and the distinction that this man has in both the scientific and organizational phases of medical activities that it is the unanimous feeling of the San Francisco delegation to this convention that this man's name be offered in nomination to the office as President-Elect of the California Medical Association.

And at this time I feel greatly honored and highly privileged to offer in nomination for this office the name of Sidney Shipman. Thank you. (Applause.)

SPEAKER CHARNOCK: The name of Dr. Sidney Shipman has been placed in nomination.

DR. GRAESER (Alameda County): Mr. Speaker: I would like to second the nomination of Dr. Shipman.

SPEAKER CHARNOCK: Thank you.

DR. SAMPSON (Los Angeles): I should like to second the nomination of Dr. Shipman and move the nominations be closed.

SPEAKER CHARNOCK: It has been moved that the nominations be closed. Is there a second?

A DELEGATE: Second.

SPEAKER CHARNOCK: Those who are in favor will signify by saying "aye." To the contrary?

... There being no further discussion, the motion was put to a vote and it was unanimously carried. ...

SPEAKER CHARNOCK: The nominations are closed. How will you vote?

A DELEGATE: By acclamation.

SPEAKER CHARNOCK: All those in favor of Dr. Shipman as President-Elect of the California Medical Association will reply with a resounding "aye." To the contrary?

... There being no discussion, the motion was put to a vote and it was unanimously carried. ...

SPEAKER CHARNOCK: Hearing nothing to the contrary, the election is declared unanimous. I will appoint Dr. Cline of San Francisco and Dr. MacLean of Alameda County to escort Dr. Shipman to the rostrum. (Standing applause.)

Dr. Shipman's election is declared unanimous.

... The Chair was assumed by Vice-Speaker Bailey. ...

VICE-SPEAKER BAILEY: The next order of business is the nomination of the Speaker, California Medical Association House of Delegates. Do I hear any nominations? Dr. Craig.

DR. CRAIG (Los Angeles County): Mr. Speaker, I am not going to take the time of this organization to make a eulogistic speech because all of you know the man whom I am going to present, know him possibly better than I if that is possible, and you know his ability and I am sure you want him to continue in his office. I am placing in nomination for Speaker the name of Donald Charnock. (Applause.)

VICE-SPEAKER BAILEY: Donald Charnock.

DR. DOZIER: Mr. Speaker, it gives me great pleasure to second the nomination.

DR. RANDALL: I should like to second.

VICE-SPEAKER BAILEY: The nomination has been seconded by Dr. Randall of Los Angeles.

A DELEGATE: I move the nominations be closed.

A DELEGATE: Second.

VICE-SPEAKER BAILEY: Those in favor of closing the nominations say "aye." Opposed?

... There being no discussion, the motion was put to a vote and it was carried. ...

VICE-SPEAKER BAILEY: How will you vote?

A DELEGATE: Acclamation.

VICE-SPEAKER BAILEY: All in favor say "aye." Opposed?

... There being no discussion, the motion was put to a vote and it was unanimously carried. ...

VICE-SPEAKER BAILEY: Dr. Charnock, you are unanimously elected. (Applause.)

... The Chair was assumed by Speaker Charnock. ...

SPEAKER CHARNOCK: Thank you very much, ladies and gentlemen, for this election.

The next order of business is the election of a Vice-Speaker.

DR. SAMPSON: Mr. Chairman, a man who is known to you all who is the present Vice-Speaker of this body, who graduated with me from the same class in medical school. I have known him for the past—I was going to say twenty-five years but it is awfully close to thirty years by now—and that is an awfully long time. During that time I have known Wilbur Bailey to be an honest man, a man of high integrity.

At this time it gives me great pleasure to place his name before you in nomination for the position of Vice-Speaker.

DR. CHARNOCK: The name of Dr. Bailey has been placed in nomination for Vice-Speaker. Dr. Sherman.

DR. SHERMAN: May I have the honor and privilege of seconding that nomination?

SPEAKER CHARNOCK: It has been seconded by Dr. Sherman. Are there any further nominations?

The Chair hearing none, declares the nominations closed. They are closed. How will you vote?

A DELEGATE: Acclamation.

SPEAKER BAILEY: It has been moved and seconded that we vote by acclamation. All those in favor of

Dr. Bailey staying in his position as Vice-Speaker will signify by saying "aye." To the contrary?

... There being no further discussion, the motion was put to a vote and it was unanimously carried. ...

SPEAKER CHARNOCK: Dr. Bailey is elected. (Applause.)

The next order of business is the election of the District Councilors. Third District Council position is open, Dr. H. Clifford Loos has been nominated. Will the Los Angeles delegation please make their record? Dr. Price of Los Angeles County.

DR. PRICE: Speaker, members of the House: I wish to place the name of H. Clifford Loos in nomination as Councilor of the C.M.A. from the Third District. He has served well and we would like to have him back.

SPEAKER CHARNOCK: The Third District has selected Dr. H. Clifford Loos as their delegate from the Third District. Is there any challenge from the floor?

DR. CRANE: Members of the House of Delegates: I wish to challenge the candidacy of Dr. Loos for two reasons. The first reason, the caucus which nominated him was held at the Statler Hotel and according to the By-Laws this must be a vote of the delegates in secret ballot. At that meeting both delegates and alternates voted and it was not a secret ballot. This is just a technical side of it.

Now from the standpoint of what is more important—I know all of you men who were here at the opening of this session heard Hassard tell us about the bill that is coming before Congress with relation to financing of closed panel practice. I am wondering what our position will be if one of our alternates to the A.M.A., and if one of our Councilors for the California Medical Association is one of the biggest proponents of closed panel practice.

It seems to me where the situation has reached a point where some of our main leaders of the County Medical Society of Los Angeles are letting prevail their deep friendship for Dr. Loos—it is a friendship that I think is wonderful. Cliff is a very likable man. But when these men let their deep friendship for this man interfere with their good judgment in picking him for these high important positions then I think it is time for somebody, even from one of the branches, to get up and protest, if nothing else. (Applause.)

For these reasons, because I feel that this man does not represent the thinking of American medicine, for these reasons I challenge the candidacy of Dr. Loos.

SPEAKER CHARNOCK: Dr. Crane has challenged the candidacy of Dr. Loos according to our By-Laws on the election of Councilors—excuse me, according to our Constitution in the election of Councilors, Article III, Section 11:

"A committee, consisting of the President, the President-Elect and one delegate appointed by the Speaker from the Councilor District involved called the Qualification Committee, shall consider all

grounds upon which the nominee is challenged and report back the House. If the Committee reports in favor of confirming the nominee's election the Speaker shall declare him elected. If the Committee reports against confirming the nominee's election a three-fourths affirmative vote shall be necessary to sustain the report of the Committee."

The chairman can appoint only one member to that committee, the President and the President-Elect are automatically appointed according to the Constitution. The chairman appoints Dr. Lyle Craig as the delegate from the Councilor District No. 3. If you gentlemen will decide that question and report back we will go on to the Sixth District comprising Fresno and the adjacent Districts. Will the chairman of the delegation from the Sixth District speak?

A DELEGATE: Mr. Chairman, point of order, please. Dr. Crane comes from Pasadena. Is that District 4 or District 3?

SPEAKER CHARNOCK: It is Los Angeles County, Doctor. He is from the Los Angeles County district. It is not just District No. 3.

A DELEGATE: Thank you.

SPEAKER CHARNOCK: I will check that for you.

DR. SAMPSON: I would like to raise a point of order again because he is from District 3 and Dr. Crane is from District 4.

SPEAKER CHARNOCK: The Chair stands corrected. May we have the report from the Sixth District while we are finding the man from District 3.

DR. HALLEY: Mr. Chairman, I am Dr. Halley from District 6, chairman of that District, and we have called this in traditional fashion and we present the name of Dr. Henry A. Randel.

SPEAKER CHARNOCK: The name of Dr. Henry A. Randel has been placed in nomination—selection, rather, from the Sixth District. Is there any challenge to Dr. Randel?

The Chair hearing none, declares Dr. Randel elected Councilor from the Sixth District.

The Ninth District, Alameda County.

DR. GRAESER: Mr. Speaker, our delegates met duly and reaffirmed our selection of Dr. Donald Lum.

SPEAKER CHARNOCK: Is there any challenge to the selection of Dr. Donald Lum?

The Chair hearing none, accepts the selection of the Ninth District.

The Eighth District comprising San Francisco has now a vacancy for a two-year term made by the selection of our new President-Elect. Will we hear from the Eighth District?

DR. RIXFORD: Mr. Speaker, I am Emmet Rixford, chairman of the San Francisco delegation. In a caucus meeting more than twenty-fours ago this delegation met and by secret majority vote elected Dr. Sam Sherman as Councilor from the Eighth District to fulfill the vacancy created by the election of Dr. Shipman to the office of President-Elect.

Dr. Sherman is currently President of the San Francisco Medical Society, formerly Director of

that Society, chairman of the Union Health Plan Study Group, and a member of numerous other committees. I have known Dr. Sherman since I first started in medicine many years ago. I know him to be a very vigorous worker, a tireless worker, and a fine and honest man.

Mr. Speaker, it gives me great pleasure to report the result of this election.

SPEAKER CHARNOCK: The Eighth District has nominated Dr. Sherman to represent them. Is there any challenge? The Chair hearing none, declares Dr. Sherman elected.

To clear up the question about Pasadena, may we say that within our Constitution, District No. 3 and District No. 4 both comprise the County of Los Angeles equally, so Los Angeles has two Councilors but anybody within the County of Los Angeles in the Chair's opinion may serve upon that committee, and I shall appoint Dr. Craig to serve upon that committee.

DR. REMMEN: Will that committee hear witnesses or not?

SPEAKER CHARNOCK: There is no provision in the By-Laws for them to do that. What the committee does is to arrive at a conclusion as I just read.

"The Qualifications Committee shall consider all grounds upon which the nominee is challenged and report back to the House."

That can be done at any time during the session.

DR. REMMEN: Mr. Chairman, I would assume then that since they are to consider all grounds that they would hear witness because otherwise, where would they get evidence or information?

SPEAKER CHARNOCK: You are correct, Dr. Remmen. The Qualifications Committee has the opportunity to do that.

DR. CRAIG: Mr. Speaker, this is all out of the blue sky to me and I would like to have some evidence.

SPEAKER CHARNOCK: A question has been raised, gentlemen, when this committee shall meet and who shall be the chairman. According to the Constitution the Qualifications Committee shall consist of the President, the President-Elect and one delegate. It is the ruling of the Chair that the President shall be the chairman, the President-Elect and one delegate, Dr. Craig, shall comprise the balance of the committee. But of course this committee will have to meet when the House is not in session and it is the suggestion that they have their first meeting at noon today in a room which will be announced later. I should suggest that. They will meet in Room 6333. We will adjourn this House at 12:00 o'clock and they can meet. Any member of the House may give testimony.

The next order of business is Councilor-at-Large. First is Dr. Arthur E. Varden from San Bernardino, term expiring.

DR. PRICE (Orange County): Mr. Speaker, I should like to place in nomination the name of Dr. Arthur E. Varden to succeed himself as Councilor-at-Large.

SPEAKER CHARNOCK: The name of Dr. Varden has been placed in nomination.

A DELEGATE: I would like to second the nomination of Dr. Varden.

SPEAKER CHARNOCK: It has been—

A DELEGATE: I should like to second.

DR. MOORE (San Diego): I would like to second the nomination.

SPEAKER CHARNOCK: Are there other seconds? Are there any further nominations for this position?

A DELEGATE: I move the nominations be closed.

SPEAKER CHARNOCK: It has been moved and seconded that the nominations be closed. Those in favor will signify by saying "aye."

... There being no discussion, the motion was put to a vote and it was unanimously carried. ...

SPEAKER CHARNOCK: How will you vote?

A DELEGATE: Acclamation.

SPEAKER CHARNOCK: Those in favor of Dr. Varden to succeed himself as Councilor-at-Large will signify by saying "aye." To the contrary?

... There being no further discussion, the motion was put to a vote and it was unanimously carried. ...

SPEAKER CHARNOCK: Dr. Varden is elected to succeed himself.

The next position of Councilor-at-Large, Dr. Ivan C. Heron, San Francisco, whose term is expiring. Dr. Rixford of San Francisco.

DR. RIXFORD: Mr. Speaker, as chairman of the San Francisco delegation I have been requested by that delegation to place in nomination for Councilor-at-Large Dr. Ivan C. Heron. Dr. Heron is Past President of the San Francisco Medical Society, Past President of the San Francisco Academy of General Practice, Past President of the California Academy of General Practice, chairman of the Board of the American Academy of General Practice and C.M.A. Councilor-at-Large for the past term. Mr. Speaker, I nominate Dr. Ivan C. Heron for Councilor-at-Large to succeed himself. (Applause.)

SPEAKER CHARNOCK: The name of Dr. Heron has been placed in nomination.

A DELEGATE: I would like to second the nomination of Dr. Heron.

DR. BURWELL (Los Angeles): I would like to second.

DR. DAVIS (Santa Clara County): We should certainly like very much to second the nomination.

SPEAKER CHARNOCK: Are there any further nominations for this position?

A DELEGATE: I move they be closed.

SPEAKER CHARNOCK: The Chair hearing none, declares the nominations closed. How will you vote?

A DELEGATE: Acclamation.

SPEAKER CHARNOCK: Those in favor of Dr. Ivan C. Heron as Councilor-at-Large for a three-year term will signify by saying "aye." To the contrary?

... There being no further discussion, the motion was put to a vote and it was unanimously carried. ...

SPEAKER CHARNOCK: Dr. Heron is declared elected.

The next order of business is delegates to the American Medical Association elected for a term of two calendar years, to serve for two calendar years starting January 1, 1955. The first office is that of the incumbent, Dr. H. Gordon MacLean of Oakland.

DR. MACLEAN: Mr. Speaker and members of the House: Being the incumbent delegate to the A.M.A. I wish to state I am not a candidate for that office. Therefore I would like to present to you in nomination a man who has many qualifications. He has served in two county medical societies, which is quite unusual, on the Council of the Contra Costa Medical Society and president of that organization, and one of the original Councilors of the Alameda-Contra Costa Medical Association. He also has served the C.M.A. on medical committees, on the Committee of Fee Schedules, you will remember, which was a very tough job, and he has been chairman of the Committee on Medical Economics.

Also, from a civic standpoint, a few years ago he was named the Citizen of the Year in Richmond, California. He also has been the leading and guiding light in the building of the new hospital out there. In case you think this man is purely serious I assure you he also has a great sense of humor. He has been voted in the A.M.A. the very finest plastic cheese sandwich maker. And I assure you, if you doubt any of those statements, if you would consult with Dr. Robertson Ward and Dr. Pete Green you will find out that he is exactly what I say.

However, he really, in spite of some of these latter qualifications, is a very active man and I wish to give you in nomination the dean of alternates. He has served as dean of alternates for many years, L. H. Fraser. (Applause.)

SPEAKER CHARNOCK: Dr. Fraser's name has been placed in nomination. Dr. Atwood.

DR. ATWOOD: It gives me great pleasure to second the nomination of the unanimous choice of our delegation, Dr. Fraser. (Applause.)

SPEAKER CHARNOCK: Dr. Fraser's name has been seconded.

DR. MILLER (San Mateo County): It gives me great pleasure to second that nomination and keep him behind the eight ball. (Laughter.)

SPEAKER CHARNOCK: It has been seconded. Do I hear any further nominations for this position? The Chair hearing none, declares these nominations closed. Those who are in favor of Dr. Fraser as a delegate to the American Medical Association for a two-year term behind the eight ball (laughter) will please signify by saying "aye." To the contrary?

... There being no further discussion, the motion was put to a vote and it was unanimously carried. ...

SPEAKER CHARNOCK: Dr. Fraser is unanimously elected.

The second position is Dr. E. Vincent Askey of Los Angeles, term expiring.

DR. COOK (Los Angeles): Mr. Speaker, Dr. Askey needs no introduction to this group. It gives me great pleasure to nominate Dr. Askey for delegate to the American Medical Association to succeed himself.

SPEAKER CHARNOCK: Are there any further nominations for this position? I am afraid we would be behind the eight ball if we nominated anybody else. (Laughter.)

The Chair hearing none, declares the nominations closed. They are closed. Those in favor of Dr. E. Vincent Askey for this position will signify by saying "aye." To the contrary?

... There being no discussion, the motion was put to a vote and it was unanimously carried. ...

SPEAKER CHARNOCK: Dr. Askey has been elected.

The next position is that held by Dwight L. Wilbur of San Francisco, term expiring.

DR. RIXFORD: Mr. Speaker, as chairman of the San Francisco delegation I have been requested by that delegation to nominate as delegate to A.M.A. Dr. Donald M. Campbell.

Dr. Campbell is currently a director of the San Francisco Medical Society. He is past secretary-treasurer and chairman of the Finance Committee of that society. He is the current President of the San Francisco Academy of General Practice. He has been chairman of the C.M.A. Committee on Problems of the Aging, and chairman of the National Academy of General Practice Committee on Problems of the Aging. He is chairman of the Northern Section of the Public Health League.

Mr. Speaker, I nominate Dr. Donald M. Campbell.

SPEAKER CHARNOCK: The name of Dr. Campbell has been placed in nomination. Dr. Garland.

DR. GARLAND: Mr. Speaker and members of the House: I think we all agree that change is good and that there are times when it is essential, but change is not automatically good at all times. Experience and training in the techniques of dealing with medical organizational problems on the national level come slowly. Dr. Dwight Locke Wilbur, because of his long familiarity with the scientific and organizational problems facing us in medicine, both in San Francisco, in California and in the United States as a whole, and because of his own stature as an outstanding physician is particularly fitted for this position. It is therefore my privilege as a member of the San Francisco delegation to nominate Dr. Wilbur to succeed himself as delegate.

SPEAKER CHARNOCK: The name of Dr. Wilbur has been placed in nomination.

PAST PRESIDENT GOIN: Mr. Speaker, members of the House of Delegates: This is the first occasion on which I have appeared on the floor of this House in my capacity as an ex-officio delegate, ex-officio member of the House, and I am happy for the occasion of my appearance which is to second the nomination of Dr. Dwight Wilbur for the position of delegate to the American Medical Association. The office of

delegate to the American Medical Association is an extremely important office and one which becomes more important annually with the increasing complexities of the problems which confront American medicine.

Dr. Wilbur is a man with six, perhaps eight years' experience in the House of Delegates. Dr. Wilbur is a man of unquestionable integrity and honor and of great intellectual ability, and for these characteristics is respected unanimously by the members of that House. From the vantage point of ten years of service in the House I might tell you that there are certain similarities between the House of Delegates with the American Medical Association and the U. S. Senate. In particular, almost all things get done in committees and appointment to committees goes almost entirely by seniority, and this is particularly true of appointment of chairmen of committees. So if a man is to do his work, if he is to contribute his thinking, if he is to put in his ability it is important that he have enough seniority to become a member or chairman of the various committees.

For this reason, and with great pleasure, I second the nomination of Dr. Wilbur, and I say that it is my serious and considered judgment that to fail to return him to office would be a serious and costly error. (Applause.)

DR. HERON: Mr. Speaker, members of the House: I would like to speak for the candidacy of Donald Campbell. I have known Dr. Campbell for—well, ever since he came down from Canada to intern at Stanford with me. Since then we have practiced in the same hospital group.

Dr. Campbell is a general practitioner. He is a grass roots practitioner. During all his term in this hospital he has earned the respect and the affection of his confreres. He has taken a great deal of interest in organized medicine and he does have a very great interest in the future of our organization. I can recommend Dr. Campbell as a very worthy addition to our very worthy delegation at the A.M.A. It is true that he might now and then tell a Highland story, but being half Scotch myself, not full, you will notice, I don't think that is so bad. I therefore take great pleasure in seconding the nomination of Donald Campbell. (Applause.)

DR. MACLEAN: Mr. Speaker, members of the House: As chairman of the delegation to the A.M.A. I have observed our incumbent, Dr. Wilbur. He is everything that Dr. Goin said he was. It gives me great pleasure to second his nomination.

SPEAKER CHARNOCK: Dr. Ewing Turner from Los Angeles County.

DR. TURNER: Mr. Speaker, members of the House: It seems to me that medicine today is up against some very trying times, and it seems to me that in these trying times organized medicine needs men of experience to direct the policies in the A.M.A. Therefore, it gives me great pleasure in seconding the nomination of a man who has intelligence, who has experience and a willingness to work. It gives

me great pleasure in seconding the nomination of Dr. Dwight L. Wilbur.

SPEAKER CHARNOCK: Dr. Price from Orange County.

DR. PRICE: Mr. Speaker, members of the House of Delegates: The chairman of the Orange County representatives has asked me—and I being one of those usurpers of the \$6,000 and \$25 a day, and sitting and listening to the counsel of Dr. Dwight Wilbur and all of the help that he has given me in my novice stage—it gives me great pleasure for the Orange County delegation to second the nomination of Dwight L. Wilbur. (Applause.)

SPEAKER CHARNOCK: Are there any further nominations for this position? Dr. Bender from San Francisco.

DR. BENDER: Mr. Chairman, members of the Delegation: I have had nothing to do whatsoever as a member of the San Francisco delegation with the nomination of either man. I have no interest in the political aspirations or the success of either man. In my estimation they are both pretty good men. I am interested only in representative government. As I pointed out last December, when the issue came up of a contest between two men in the Los Angeles delegation, the delegate which nominates a candidate is in the best position to know whether or not that candidate is the best representative of his constituents at home. The doctor in the area which is represented by a delegate has no other way to express his opinion of how the affairs of the American Medical Association shall be carried on excepting through the delegation and the selection by the delegation of a nominee for that office.

Therefore, I urge you to vote in the interest of pure representative government for the nomination of the San Francisco delegate.

SPEAKER CHARNOCK: Dr. Cline.

DR. CLINE: Mr. Speaker, I would like to call to the attention of the House that this House represents California, that it does not represent when it sends its delegates to the A.M.A. any individual segment of California. They go there as representatives of California to carry out your wishes, and I think that it is improper to ask for support or opposition to a candidate on the basis that he happens to come from a particular location. (Applause.)

SPEAKER CHARNOCK: Are there any further nominations for this office? The Chair hearing none, declares the nominations closed. They are closed.

If you will look in your pocket you will find a ballot. On ballot number one you will write the name of the gentleman whom you desire. The Chair appoints Dr. Stanley Truman of Alameda, Dr. Louis Bullock of Los Angeles and Dr. Dave Dozier of Sacramento as tellers.

A DELEGATE: Mr. Young has asked me to announce that twenty-three alternates from Los Angeles do not have their ballots. You will please go to the rear of the room and pick up your book of ballots up there. Thank you.

SPEAKER CHARNOCK: Will the secretaries of each delegation see that only the accredited delegate or alternate vote, and will the tellers please watch from whom they are collecting ballots. The ballots are supposed to go only to those people seated in the House.

SPEAKER CHARNOCK: At this time while this balloting is going on we can save a little time by going on with the selection of delegates of A.M.A. The next office is that held by Dr. Donald Cass of Los Angeles, term expiring.

DR. GOIN: Mr. Speaker, members of the House: During the past eight years the nominee that I am suggesting to you has served on the team very ably as a delegate to the American Medical Association. It is very fitting that he be renominated. So at this time I would like to place in nomination the name of Donald Cass to succeed himself for two years. (Applause.)

SPEAKER CHARNOCK: The name of Dr. Donald Cass has been placed in nomination. Are there any further nominations for this position?

A DELEGATE: I move the nominations be closed.

SPEAKER CHARNOCK: It has been moved and seconded that the nominations be closed. Those in favor will signify by saying "aye." Contrary?

... There being no discussion, the motion was put to a vote and it was unanimously carried. ...

SPEAKER CHARNOCK: I presume you will vote by acclamation. Those in favor of Dr. Donald Cass will signify by saying "aye." To the contrary?

... There being no discussion, the motion was put to a vote and it was unanimously carried. ...

SPEAKER CHARNOCK: Dr. Cass is unanimously elected.

The position of J. Lafe Ludwig of Los Angeles, term expiring.

DR. WADSWORTH (Los Angeles): It gives me pleasure to present to you the name of J. Lafe Ludwig to succeed himself. He has been exceptionally active and particularly apt in this opportunity given him to serve us in the House of Delegates of the A.M.A. I know of nobody who has his, shall we call it, political aptitude of meeting a man once and knowing him from then on. I strongly urge you to send him back to represent us.

SPEAKER CHARNOCK: The name of Dr. J. Lafe Ludwig has been placed in nomination. Are there any further nominations for this position? The Chair hearing none, declares the nominations closed.

Those who are in favor of Dr. J. Lafe Ludwig will signify by saying "aye." To the contrary?

... There being no discussion, the motion was put to a vote and it was carried. ...

SPEAKER CHARNOCK: Dr. Ludwig is elected. Are there any further ballots in the contest from regularly seated delegates? Are there any further ballots? This is your last chance.

The balloting is now closed.

The position is that of Dr. R. Stanley Kneeshaw of San Jose, term expiring.

DR. RAY (San Mateo): It is a great pleasure to place in nomination the name of R. Stanley Kneeshaw to succeed himself. Dr. Kneeshaw was for some nine years Councilor of this society and a Past President, and it is indeed an honor to place his name in nomination. (Applause.)

SPEAKER CHARNOCK: The name of Dr. R. Stanley Kneeshaw has been placed in nomination.

A DELEGATE: I should like to second the nomination of Dr. Kneeshaw. There is no controversy in our district. (Laughter.)

SPEAKER CHARNOCK: Are there any further nominations for this position? The Chair hearing none, declares the nominations closed. Those in favor of Dr. R. Stanley Kneeshaw of San Jose will signify by saying "aye." To the contrary?

There being no discussion, the motion was put to a vote and it was unanimously carried. ...

SPEAKER CHARNOCK: Dr. Kneeshaw is unanimously elected.

... The Chair was assumed by Vice-Speaker Bailey. ...

VICE-SPEAKER BAILEY: Next is Dr. Leopold Fraser, an alternate to the American Medical Association. The incumbent is Dr. Leopold H. Fraser of Richmond, alternate to H. Gordon MacLean. Do we have a nomination for this position?

DR. DAVID DUGAN (Alameda County): The Alameda-Contra Costa County delegation has given me the privilege of nominating for this high office a man in our group in whom we all have the utmost confidence. His presence on this floor for the past twelve years, during which time he has never missed a caucus, as well as his background of experience, having been a President of our County Society, a member in good standing for many years as well as the chairman of the Malpractice Committee makes his qualifications unquestionable. It gives me a great deal of pleasure to submit Dr. C. E. Attwood for this position.

VICE-SPEAKER BAILEY: Dr. Cy Attwood has been nominated. Dr. Hodges.

DR. HODGES: I have known Dr. Attwood for a number of years. You can do no better than to elect Dr. Attwood. I would like to second this nomination.

VICE-SPEAKER BAILEY: Dr. Attwood has been seconded. Is there anything further? We will declare the nominations closed. Will you vote by acclamation? All those in favor will say "aye." To the contrary?

... There being no discussion, the motion was put to a vote and it was unanimously carried. ...

VICE-SPEAKER BAILEY: Dr. Attwood is elected.

Second is Dr. H. Clifford Loos of Los Angeles, present alternate.

DR. HOFFMAN (Los Angeles): Mr. Speaker, ladies and gentlemen of the House: In view of his past experience and in view of his service to his state

organization, I wish to nominate Dr. H. Clifford Loos to succeed himself as alternate. Thank you.

VICE-SPEAKER BAILEY: Any further nominations? The Chair hearing no further nominations, declares the nominations closed. They are closed. Will you vote by acclamation? All those in favor will say "aye." Opposed?

... There being no discussion, the motion was put to a vote. ...

VICE-SPEAKER BAILEY: Dr. Clifford Loos is elected, there being—well, I think we'd better have a standing vote. We always have to get these things straight or it can, of course, be a secret ballot. As a matter of fact, Mr. Speaker, I think it should be a secret ballot. We want—(Applause.)

Well, we will try it again. How do you want to vote, by acclamation or secret ballot?

A DELEGATE: Secret ballot.

VICE-SPEAKER BAILEY: That is the end of it. If there is ever a request for a secret ballot there has to be one. It will be on ballot number two and the question will be whether you wish to sustain Dr. Loos or not.

A DELEGATE: Mr. Chairman, point of order. It is not automatic to make a secret vote. You have a right to move a secret ballot, whereupon you take a vote as to whether you wish a secret ballot. I think that that should be done if anybody desires a secret ballot then they can move that we have a secret ballot. Otherwise it does not automatically go in.

VICE-SPEAKER BAILEY: Well, you are right with this being a point. We then shall ask for the motion to be a secret ballot and that will give us a vote on it.

A DELEGATE: Mr. Chairman, I move we have a vote on the second ballot.

VICE-SPEAKER BAILEY: It has been moved. Is there a second?

A DELEGATE: Second.

VICE-SPEAKER BAILEY: Is there further discussion? Those in favor of the secret ballot will say "aye." Opposed?

DR. LUM: Mr. Speaker, for a point of order, exactly what are we voting on on this ballot? There is one name that has been nominated.

VICE-SPEAKER BAILEY: We are voting whether to sustain the one name, whether this man—if you vote yes you vote to sustain Dr. Loos. If you vote no you are voting against Dr. Loos. And it must be yes or no. Yes sustains Dr. Loos and no is against him.

Will the tellers please pass the ballots out, ballot number two.

The tellers will be Dr. Dozier, Dr. Burt Davis and Dr. Sam Randall.

DR. SAMPSON: Mr. Chairman, I rise to a point of order. It seems to me that there is only one name, that we vote yes or we don't vote.

A DELEGATE: Will you repeat those names?

VICE-SPEAKER BAILEY: Dr. Dozier, Dr. Davis and Dr. Randall. Will you please collect the ballots? This will be vote number two, the coffee-colored ballot.

A DELEGATE: Mr. Speaker.

VICE-SPEAKER BAILEY: Yes.

A DELEGATE: What happens if the noes win?

VICE-SPEAKER BAILEY: Nothing happens.

A DELEGATE: Mr. Chairman, wouldn't this be less confusing if we knew what to do? There is a question before the House and it has not been decided. That will be decided at some later time today.

VICE-SPEAKER BAILEY: Well, no, it better be—

A DELEGATE: I would like to see that held over until some other time today.

VICE-SPEAKER BAILEY: No. I think we have to proceed with the election. We have already announced it and we will have to proceed with it and then decide what to do next.

Now, Dr. Cass, were you recognized? This is to talk on the subject of Dr. Doughty?

DR. CASS (Los Angeles): I would like to nominate J. Frank Doughty to succeed himself to the A.M.A. House of Delegates. Dr. Doughty is a very active member of the Rural Health Commission of the American Medical Association.

VICE-SPEAKER BAILEY: Dr. Doughty has been nominated to succeed himself.

DR. ARMANINO (San Joaquin County): I would like to second the nomination of Dr. Doughty.

VICE-SPEAKER BAILEY: The nomination of Dr. Doughty has been seconded. Are there any further nominations? The Chair hears no further nominations and therefore declares the nominations closed. How will you vote? By acclamation? All those in favor of Dr. Doughty will say "aye." Opposed?

... There being no further discussion, the motion was put to a vote and it was unanimously carried. ...

VICE-SPEAKER BAILEY: Dr. Doughty is declared elected.

Next is the office of Dr. J. Norman O'Neill of Los Angeles, alternate for Dr. Cass. Do I hear nominations?

DR. LONG (Los Angeles): I would like to nominate J. Norman O'Neill to fill his own shoes. I might remind you these have always been working shoes and they are always pointed in the right direction. I would like to nominate J. Norman O'Neill to succeed himself as an alternate to Dr. Cass.

VICE-SPEAKER BAILEY: Dr. J. Norman O'Neill has been nominated to succeed himself as an alternate to Dr. Cass. Are there any further nominations to the office? There are no further nominations to the office, therefore the nominations are declared closed. Will you vote by acclamation? All those in favor of Dr. O'Neill will say "aye." Opposed?

... There being no discussion, the motion was put to a vote and it was unanimously carried. ...

VICE-SPEAKER BAILEY: Dr. O'Neill is declared elected.

Next is Dr. H. Milton Van Dyke of Long Beach. Are there any further nominations for this office? Dr. Ewing Turner.

DR. TURNER: As chairman of the Los Angeles delegation, I'd like to place in nomination the name of H. Milton Van Dyke of Long Beach to succeed himself.

VICE-SPEAKER BAILEY: Dr. Milton Van Dyke to succeed himself. Are there any further nominations?

A DELEGATE: Move the nominations be closed.

VICE-SPEAKER BAILEY: Move to close the nominations.

A DELEGATE: Second it.

VICE-SPEAKER BAILEY: All those in favor of closing the nominations will say "aye." Opposed?

... There being no discussion, the motion was put to a vote and it was unanimously carried. ...

VICE-SPEAKER BAILEY: You will vote by acclamation? All those in favor of Dr. H. Milton Van Dyke will say "aye." Opposed?

... There being no discussion, the motion was put to a vote and it was unanimously carried. ...

VICE-SPEAKER BAILEY: Dr. Van Dyke is declared elected.

Next, Dr. Burt Davis—Doctor.

VICE-SPEAKER BAILEY: Dr. Burt Davis is next. Do we hear anyone?

DR. MILES (Monterey County): The qualities we seek in a person that we select as an alternate or delegate to the A.M.A. should have these qualifications: capacity to work, capacity to make friends, capacity for organization, and I might add a just plain capacity. (Laughter.) The man whose name we place in nomination certainly has the first three qualifications and I haven't taken it upon myself to challenge him on the fourth. (Laughter.)

We of the Seventh District have had the opportunity to see his readiness to serve in any capacity that we ask. We have seen the tenacity with which he has fought for what he thought was right. When he is given a job he keeps working at it or goes down swinging. His dedication to the cause of organized medicine takes up a great part of his working time. He has one other quality I think unique. As one looks down the roster of doctors' names we see a lot of initials placed here and there, either front or back, but this man has a name that is unique. It gives it a quality that is easy to remember and that is just plain Burt Davis.

Once you meet Burt you remember him. And I think that that quality is something that we sometimes overlook because if you remember the man, you remember what he has said, and I think that is true here and I think that will be true at the A.M.A. Convention.

I think that Dr. Bender will agree too that we are getting our money's worth sending Burt back because I don't think I could send him for freight. (Laughter.) You have to send him first class.

So I say, let's spend our money well and elect Burt Davis as an alternate to succeed himself.

VICE-SPEAKER BAILEY: Is there a second? Dr. Burt Davis has been nominated.

DR. FOX (Santa Clara): I wish to second the nomination of Dr. Burt, "R" for Resolution, Davis. (Laughter.)

VICE-SPEAKER BAILEY: Burt "R" for Resolution, Davis. Any further nominations? There being none, the Chair declares the nominations closed. Will you vote by acclamation?

A DELEGATE: Yes.

VICE-SPEAKER BAILEY: All those in favor of Dr. Davis will say "aye." Opposed?

... There being no further discussion, the motion was put to a vote and it was unanimously carried. ...

VICE-SPEAKER BAILEY: Dr. Davis is declared elected.

...The Chair was assumed by Speaker Charnock....

SPEAKER CHARNOCK: The tellers have reported in the first ballot, Dr. Wilbur, 184; Dr. Campbell, 89; a total of 273 ballots cast. Dr. Wilbur is declared elected. (Applause.)

The next offices open are those for C.P.S. Trustees. According to the Constitution and By-Laws of C.P.S., nominations for Trustee are made by the Council of the California Medical Association. The names that you have before you are as follows: C. Glen Curtis of Brea; Philip N. Baxter of Oakland; Thomas N. Foster of San Jose; J. Norman O'Neill of Los Angeles. Are there any nominations from the floor for these positions?

DR. SHIPMAN: Mr. Speaker and members of the House: The Council a few weeks ago also nominated a businessman, Ransome Cook, Senior, Vice-President of the American Trust Company of San Francisco. (Applause.) It was uncertain whether Mr. Cook would accept this nomination. He was in Asia at the time. So when he returned I took him to lunch and asked him if he would be willing to serve again. He had done such outstanding service for C.P.S. in the past that I told him that the Council's opinion was that we needed the very highest quality of business management in C.P.S. and we knew of no one who could give it to us better than Ransome Cook. And finally, after some reluctance, he agreed.

The Council therefore would like to place in nomination the name of Ransome Cook of San Francisco in addition to the four names you have heard.

SPEAKER CHARNOCK: The name of Mr. Ransome Cook is added to that list of four. We can vote for them singly or in toto.

A DELEGATE: In toto.

SPEAKER CHARNOCK: It is the opinion of the House that they will vote in toto. Are there any other nominations for these positions as C.P.S. Trustees? The House will understand that the name of Mr. Ransome Cook is an additional vacancy. There is no contest. There are the five positions open. Are there any further nominations?

A DELEGATE: Move the nominations be closed.

SPEAKER CHARNOCK: The Chair hearing none, declares the nominations closed. They are closed. Those who are in favor of this group of gentlemen will signify by saying "aye." To the contrary?

... There being no discussion, the motion was put to a vote and it was unanimously carried. ...

SPEAKER CHARNOCK: They are unanimously elected.

We will now have an announcement by the Secretary of the Council's nomination of members of Standing Committees for approval of your ballot.

DR. DANIELS: Mr. Speaker: The Committee on Associated Societies and Technical Groups—incidentally, the Committee on Committees was composed of Dr. Dwight Wilbur, Dr. Clifford Loos and Dr. Francis West, and their nominations are as follows:

Committee on Associated Societies and Technical Groups: Dr. Charles E. Grayson, Sacramento.

Committee on History and Obituaries: Dr. J. Marion Read, San Francisco, Chairman—Reappointed.

Committee on Hospitals, Dispensaries and Clinics: Dr. Jay J. Crane, Los Angeles, Chairman—Reappointed.

Committee on Industrial Practice: Dr. John E. Kirkpatrick, San Francisco.

Committee on Medical Economics: Dr. L. H. Fraser, Richmond, Chairman—Reappointed.

Committee on Medical Education and Medical Institutions: Dr. Loren R. Chandler, San Francisco.

Committee on Military Affairs and Civil Defense: Dr. Justin J. Stein, Los Angeles, Chairman—Reappointed.

Committee on Postgraduate Activities: Dr. J. E. Young, Fresno—Reappointed.

Committee on Public Policy and Legislation: Dr. Dan O. Kilroy, Sacramento—Reappointed.

Committee on Scientific Work: Dr. George C. Griffith, Los Angeles.

Physicians' Benevolence Committee: Dr. Axel E. Anderson, Fresno, chairman—Reappointed.

Committee on Public Relations: Dr. Frank Macdonald, Sacramento—Reappointed, and Dr. J. Lafe Ludwig, Los Angeles—Reappointed.

SPEAKER CHARNOCK: You have just heard the selections made by the Committee on Committees for your approval. Do I hear a motion approving this selection, these selections?

A DELEGATE: So moved.

SPEAKER CHARNOCK: It has been moved and seconded that the House approve these selections. Those who are in favor will signify by saying "aye." Opposed?

... There being no discussion, the motion was put to a vote and it was unanimously carried. ...

SPEAKER CHARNOCK: They are approved.

... Announcements. ...

SPEAKER CHARNOCK: Have the tellers reported on that last vote? May we have the report of the tellers on this?

DR. DOZIER: "Yes," 50, and "no," 189. (Applause.)

SPEAKER CHARNOCK: I will ask Hap Hassard to come up and please clarify the problem with us.

MR. HASSARD: Mr. Speaker, I have to beg for a little time. I have gone through Roberts Rules of Order, the By-Laws of the California Medical Association, and I am stuck at the moment because the By-Laws of the C.M.A. on an election of delegates and alternates to the A.M.A. refer to the By-Laws of the American Medical Association. We don't have them here at the moment. (Laughter.) May I defer the answer for a little while?

SPEAKER CHARNOCK: We will defer that answer for a moment.

Dr. Turner.

DR. TURNER: Mr. Speaker, if it is in order, the Los Angeles delegation would like to caucus before this item on the agenda is presented on the floor.

SPEAKER CHARNOCK: Would you care to caucus at this time or at 12:00 o'clock, or at what time do you wish to caucus?

DR. TURNER: Before this item is going to be presented.

SPEAKER CHARNOCK: All right, we will give you an opportunity then before Legal Counsel comes up with his answer and go on. We will give you the opportunity to caucus.

DR. TURNER: Do you want us to caucus now?

SPEAKER CHARNOCK: I'd just as soon get on with the business until some future time. If you will give us the place where you will caucus—

DR. TURNER: We will caucus in Room 7334 at 12:00 o'clock. Room 7334 at 12:00 o'clock. There will be a caucus of the Los Angeles delegation. Thank you.

DR. CRANE: Mr. Speaker.

SPEAKER CHARNOCK: Yes.

DR. CRANE: May I call to your attention that this other committee that you have appointed is meeting at the same time. How are we going to—

SPEAKER CHARNOCK: I realize that. If the Secretary of the Los Angeles delegation will appoint another hour for his caucus, there is a committee meeting at that time.

DR. TURNER: We'd just as soon caucus now, Mr. Speaker.

SPEAKER CHARNOCK: All right, what length of time will you require for your caucus?

DR. TURNER: Probably twenty minutes.

SPEAKER CHARNOCK: The Chair will declare a recess for twenty minutes.

... Recess. ...

SPEAKER CHARNOCK: Ladies and gentlemen, your attention just a moment. If you gentlemen from San Francisco think you have troubles (laughter) go up to Room 7334. I think it will be quite impossible to get the Los Angeles delegation back on the floor by 12:00 o'clock. With your permission we will declare the House in recess until 1:00 p.m.

... The meeting adjourned at 11:30 a.m. ...

Wednesday Afternoon Session

The Wednesday afternoon session of the House of Delegates of the California Medical Association was held in the Renaissance Room, Biltmore Hotel, Los Angeles, California. The meeting was called to order at 1:30 p.m. by the Speaker, Dr. Donald A. Charnock, who presided.

SPEAKER CHARNOCK: I am now informed there is a quorum present. May we be in order?

May we have the report of Reference Committee No. 1, Dr. Moore of Ventura? Will you please be in order, gentlemen.

REPORT OF REFERENCE COMMITTEE No. 1

DR. J. W. MOORE, Chairman: Mr. Speaker, members of the House of Delegates: I would first like to thank the members of the Reference Committee, Dr. Thomas J. Dozier of Antioch and Dr. Dave Dozier of Sacramento, for their help and assistance in preparing this report, and I would like also to present my thanks to Mrs. Barbara Rooney for serving as secretary to this committee.

Reference Committee No. 1 has reviewed the reports of the general officers, the Councilors, the standing and special committees of the California Medical Association. All of these reports are printed in the Annual Reports Bulletin and such additional reports as were made were heard at the opening session of this House of Delegates. The report of this Reference Committee will be presented in three sections for action by this House. The first section will be devoted to consideration of the reports of the officers, Councilors and special and standing committees in general.

The second section will be devoted to special comment on the report of the Blood Bank Commission and the Cancer Commission.

The third section will be devoted to a consideration of the reports of the Medical Services Commission.

Section 1. This committee wishes to commend the officers, Councilors and members of the various committees for their splendid work during the past year for our Association. Their reports reflect the devotion of a great deal of time and energy in the performance of their duties and they show splendid accomplishment in the furtherance of the ideals and objectives of the California Medical Association. This committee finds all of these reports in order and recommends their acceptance by the House.

Mr. Speaker, I move the adoption of this section of our report.

SPEAKER CHARNOCK: It has been moved and seconded that this section of the report be accepted. Is there any discussion? Those in favor will signify by saying "aye." To the contrary?

... There being no discussion, the motion was put to a vote and it was unanimously carried. ...

DR. MOORE: Section 2.—Our committee wishes to comment upon the report of the Committee on Postgraduate Activities. We feel that this committee

has continued to do excellent work in making available postgraduate programs for the members of this Association who practice in rural areas. We note that the report requests the House of Delegates to direct the Council to continue the allocation of funds for the support of this postgraduate program. We believe this is a very worthwhile expenditure of funds and recommend its approval. We also wish to comment on the report of the Cancer Commission. We feel that the activities and accomplishments of the Cancer Commission continue to be a strong force and agency for the protection of the health of the people of this state and through the years have brought a great deal of credit to themselves as well as the California Medical Association. We wish particularly to commend their fine work. The committee wishes again also to commend Dr. John Upton, chairman, and the other members of the Blood Bank Commission on their outstanding work in the field of blood bank development and operation.

Mr. Speaker, I move the adoption of this section of our report.

SPEAKER CHARNOCK: This section of the report has been moved and seconded. Is there any discussion? Those in favor will signify by saying "aye." Contrary?

... There being no discussion, the motion was put to a vote and it was unanimously carried. ...

DR. MOORE: Section 3—the Medical Services Commission Report. Prolonged hearings and discussions were held on the report of the Medical Services Commission. We feel that certain points warrant emphasis and elaboration. Their report represents the culmination of studies over a period of years by the C.M.A.-C.P.S. Study Committee and the Medical Services Commission. These bodies have carried on extensive investigations with the assistance of competent professional advice in the fields of insurance, prepaid medical care and public relations.

It is the opinion of your Reference Committee that the report points up the desirability for defining a basic policy for the C.M.A. The proposals embodied in the report amount to the establishment of such a policy. It should be emphasized that the adoption of these proposals does not close the door to the consideration of other solutions to these problems which may be proposed in the future. It should also be pointed out that these proposals do not restrict the participation of private commercial insurance carriers, writing health insurance contracts.

This Reference Committee wishes to make it clear that the implementation of the proposal in this report is embodied in specific resolutions which were submitted to the House at its first session. These resolutions will be discussed in the reports of other Reference Committees at this session. The acceptance of the Medical Services Commission report is recommended by this committee, subject to the action of the House upon the specific resolutions.

Mr. Speaker, I move the adoption of this section of our report.

SPEAKER CHARNOCK: It has been moved and seconded that this section of the report be adopted. Is there any discussion? All those in favor of this section of the report will signify by saying "aye." To the contrary?

... There being no discussion, the motion was put to a vote and it was unanimously carried. ...

DR. MOORE: Mr. Speaker, I move the adoption of the report as a whole.

SPEAKER CHARNOCK: It has been moved and seconded that this report as a whole be accepted. Is there any discussion? Those in favor will signify by saying "aye." To the contrary?

... There being no discussion, the motion was put to a vote and it was unanimously carried. ...

SPEAKER CHARNOCK: This report is accepted in whole.

Thank you very much, and we wish to thank all the members of your Reference Committee.

At this time we will take up the report of Reference Committee No. 3, Dr. Hadley, chairman.

REPORT OF REFERENCE COMMITTEE No. 3

CARL M. HADLEY, Chairman: Mr. Speaker, and members of the House of Delegates: Reference Committee No. 3, composed of Drs. Helen B. Weyrauch of San Francisco, Samuel B. Randall of Santa Cruz, and myself, Carl Hadley of San Bernardino, chairman, was assigned nineteen resolutions for consideration. We have met various delegates in studying these resolutions and submit the following report:

Resolution No. 1, introduced by Dr. Sidney J. Shipman for the C.M.A. Council.

This resolution was introduced upon request by the San Diego County Medical Society. It deals with the granting of an Honorary Membership to Dr. William Henry Geistweit, Jr., as a reward for the years of service to the San Diego County Medical Society and the California Medical Association. Your committee recommends "Do Pass."

Mr. Speaker, I move the adoption of this portion of the report.

SPEAKER CHARNOCK: It has been moved and seconded that we accept this section of the report. Is there any discussion? All those who are in favor of accepting this section of the report will signify by saying "aye." To the contrary?

... There being no discussion, the motion was put to a vote and it was unanimously carried. ...

SPEAKER CHARNOCK: It is accepted.

DR. HADLEY: Resolution No. 2, introduced by Sidney J. Shipman, changes the second "Whereas," where the words "now need" were crossed out and the word "desire" substituted, your committee recommends this resolution "Do Pass."

Mr. Speaker, I move the adoption of this section of the report.

SPEAKER CHARNOCK: It has been moved and seconded that we adopt this section of the report. Is there any discussion? Those in favor will signify by saying "aye." To the contrary?

... There being no discussion, the motion was put to a vote and it was unanimously carried. ...

SPEAKER CHARNOCK: It is accepted. Will you proceed?

DR. HADLEY: Resolution No. 3, introduced by Dr. Sidney J. Shipman for the C.M.A. Council.

This refers to the Usual-Fee Indemnity Plan. We have hyphenated the words "Usual-Fee" and recommend that this resolution "Do Pass" as amended.

Mr. Speaker, I move the adoption of this section of the report.

SPEAKER CHARNOCK: It has been moved and seconded that we adopt this section of the report. Is there any discussion? Those in favor of accepting this section of the report will signify by saying "aye." To the contrary?

... There being no discussion, the motion was put to a vote and it was unanimously carried. ...

SPEAKER CHARNOCK: It is accepted.

DR. HADLEY: Resolution No. 4, introduced by Dr. Shipman for the C.M.A. Council.

In error this resolution was introduced out of order. It should have preceded Resolution No. 3. We agree in principle with this resolution and recommend "Do Pass."

Mr. Speaker, I move the adoption of this section of the report.

SPEAKER CHARNOCK: The adoption of this section of the report has been moved and seconded. Is there any discussion? Those in favor of adopting this section of the report will signify by saying "aye."

... There being no discussion, the motion was put to a vote and it was unanimously carried. ...

SPEAKER CHARNOCK: It is accepted.

DR. HADLEY: Resolution No. 6, introduced by Dr. Shipman for C.M.A. Council.

This resolution is on the subject of enlarging the Medical Services Commission. This has been recommended by the Council and your committee agrees in principle with it and recommends "Do Pass."

Mr. Speaker, I move the adoption of this section of the report.

SPEAKER CHARNOCK: It has been moved and seconded that we accept this section of the report. Is there any discussion? Those in favor will signify by saying "aye." To the contrary?

... There being no discussion, the motion was put to a vote and it was unanimously carried. ...

SPEAKER CHARNOCK: It is accepted.

DR. HADLEY: Resolution No. 7, introduced by J. Lafe Ludwig of Los Angeles.

This resolution is on the subject of foreign trained physicians and licensure. In the second "Whereas" we have struck the word "conscientious" and substituted the word "true." In the second "Resolved" after "Board of Medical Examiners" we have added "and the American Medical Association." Your committee recommends that this amended resolution "Do Pass."

Mr. Speaker, I move the adoption of this section of the report.

SPEAKER CHARNOCK: It has been moved and seconded that we adopt this section of the report. Is there any discussion? Those in favor will signify by saying "aye." To the contrary?

... There being no discussion, the motion was put to a vote and it was unanimously carried. ...

SPEAKER CHARNOCK: It is accepted.

DR. HADLEY: Resolution No. 8, introduced by J. Lafe Ludwig of Los Angeles.

The subject of this resolution is foreign trained physicians and quality of medical care. Inadvertently this resolution was incorrectly mimeographed in that the "Resolved" paragraph should read as follows:

"Resolved, That the California Medical Association instruct its Delegates to the American Medical Association to introduce and press for adoption a resolution disapproving intern or resident training of foreign trained physicians who are ineligible for licensure in the United States, except those bona fide foreign graduates selected for training in this country and who return at the termination of said training."

Would you please correct your copy of the resolution by deleting the words "directing the Council on Medical Education and Hospitals of the A.M.A. to withhold approval of any institution that accepts for" and insert the word "disapproving" and then on the same line and after the words "resident training" insert "of."

The committee agrees with this resolution as corrected and recommends "Do Pass."

Mr. Speaker, I move the adoption of this section of the report.

... The Chair was assumed by Vice-Speaker Bailey. ...

VICE-SPEAKER BAILEY: Moved and seconded that this section of the report be adopted. Is there any discussion? There is discussion.

DR. JULIUS KAHN (Los Angeles): Thank you, Mr. Chairman.

I would like to know what is meant by "ineligible for licensure in the United States."

VICE-SPEAKER BAILEY: That is a point of information. Would you care to answer it for us, Dr. Hadley?

DR. HADLEY: I would like to ask Mr. Hassard.

... Discussion off the record. ...

VICE-SPEAKER BAILEY: Will you yield to Mr. Hassard?

MR. HASSARD: Of course, actually the requirements for license here in the United States vary somewhat state to state. There are a number of states that have requirements for eligibility that preclude the graduates of certain foreign schools from becoming eligible under certain circumstances. There is, however, no uniform requirement in each and all the forty-eight states.

DR. KAHN: While you are here, Mr. Hassard, I would like to know how this would change present practice.

MR. HASSARD: Well, the—

DR. KAHN: How the resolution would change the present practice?

MR. HASSARD: Unfortunately I do not know the present practice in all of the hospitals of the United States. It would be impossible for me to answer that question. I know that in California but I do not know it in the rest of the country.

VICE-SPEAKER BAILEY: Do you wish to know in California, Dr. Kahn?

DR. KAHN: Yes.

VICE-SPEAKER BAILEY: Would you wish to tell us what is the practice in California? What the practice is in California and how it would be altered? That is your question, Dr. Kahn?

MR. HASSARD: Yes, sir. In California we have a specific provision in the Medical Practice Act that permits intern and residency training up to a maximum period of time for physicians who are not licensed here who have registered with the Board of Medical Examiners. We have a provision that as to graduates of foreign medical schools such graduates are not eligible for licensing in California unless physicians licensed here could go to the country from which the foreign graduate graduated and be eligible for licensure there by the reciprocity statute.

This particular resolution would not, to the best of my knowledge, change current practices in California.

VICE-SPEAKER BAILEY: Dr. Kahn, the Chair being a member of the Board of Medical Examiners, would call that a fair statement of the facts. Do you care to speak for or against this resolution?

DR. KAHN: Well, then, the resolution would not in effect change present practice?

VICE-SPEAKER BAILEY: In California it would not. We do not know about all the forty-eight states.

DR. KAHN: No, I really was somewhat concerned because I practiced in a hospital where each year two or three foreign born interns are trained. Some of them turn out to be excellent practitioners. Some of them find their way onto the faculties of the various medical schools in town here and others of them—certainly I can't conceive of how they would ever get by any Board of Medical Examiners. I am disinclined to put rocks in the way of those who are worthy just because they happen perhaps to come from a foreign medical school. There are many foreign medical schools which, considering their size, go for a higher proportion of Nobel Prize winners than some of our own schools. I hope that this resolution and the foregoing one will not put rocks in the way of those who are well trained and worthy.

VICE-SPEAKER BAILEY: Then the motion stands before the House on the adoption of this portion of the resolution. Any further debate? There is none.

All those in favor of adopting this portion of the resolution say "aye." Opposed?

... There being no further discussion, the motion was put to a vote and it was carried. ...

VICE-SPEAKER BAILEY: The "ayes" have it and the motion is carried.

DR. HADLEY: Resolution No. 14, introduced by George K. Herzog, Jr., representing the San Francisco Medical Society.

The subject was left off the mimeographed report but it is on the clarification of the adoption laws. Your committee agrees with the purpose of this resolution and recommends it "Do Pass."

Mr. Speaker, I move the adoption of this section of the report.

VICE-SPEAKER BAILEY: That is on Resolution 16?

DR. HADLEY: 14.

VICE-SPEAKER BAILEY: 14, I beg your pardon. Is there any further discussion? Those in favor of the adoption will say "aye." Opposed?

... There being no discussion, the motion was put to a vote and it was unanimously carried. ...

VICE-SPEAKER BAILEY: Proceed, Doctor.

DR. HADLEY: Resolution No. 16, introduced by Grace M. Talbott, representing the San Francisco Medical Society. And again the subject of the resolution was left off the report but it had to do with the A.M.A. limiting the board training of certain hospitals and putting a minimum limit on the amount of time for board training in those hospitals.

Your committee agrees with this resolution and recommends it "Do Pass."

Mr. Speaker, I move the adoption of this section of the report.

VICE-SPEAKER BAILEY: It has been moved and seconded the section be adopted. Is there any discussion? Those in favor will say "aye." Opposed?

... There being no discussion, the motion was put to a vote and it was unanimously carried. ...

VICE-SPEAKER BAILEY: It is adopted.

DR. HADLEY: Resolution No. 18, introduced by Lewis T. Bullock, representing Los Angeles County Medical Association.

We agree in principle with this resolution but, for purposes of clarification, wish to submit the following amended resolution:

"Resolved, That this House of Delegates state its support of universal vaccination of dogs against rabies as a valuable measure for the protection of the public health; and be it further

"Resolved, That a bill to require vaccination of all dogs in California against rabies be prepared, introduced and supported in the Legislature by the representatives of the California Medical Association and further request the Council of the California Medical Association to ask the support and cooperation of other groups interested in the public health."

Mr. Speaker, we recommend that this amended resolution "Do Pass."

VICE-SPEAKER BAILEY: Moved and seconded that this resolution "Do Pass." Is there any discussion? Hearing none, all those in favor will say "aye." Opposed?

... There being no discussion, the motion was put to a vote and it was unanimously carried. ...

A DELEGATE: Mr. Speaker, point of order. Where did Resolution No. 9 get lost?

VICE-SPEAKER BAILEY: I think it went to another committee. Will the Secretary find out where nine is?

DR. HADLEY: C.P.S. got it.

VICE-SPEAKER BAILEY: C.P.S. got it.

All right, Dr. Hadley, proceed.

DR. HADLEY: We are now on Resolution No. 20. This was introduced by the Santa Cruz Medical Society, represented by Luther Newhall.

This resolution concerns medical staff membership in non-profit hospitals. Your committee has changed the second "Whereas" by substituting the word "Trustees" for the word "management" and has changed the *Resolve* and wishes to offer this substitute resolution. In its amended form, the resolution reads as follows:

"WHEREAS, The public is entitled to efficient and harmonious operation of a non-profit hospital; and

"WHEREAS, The primary responsibility of the hospital trustees is to provide facilities and the primary responsibility of the medical staff is to provide medical care; and

"WHEREAS, Even though close cooperation and many overlapping functions are involved in the provision of good care to hospitalized persons, the separate underlying responsibilities provide a natural basis for a healthy balance of power; therefore, be it

"Resolved, That the California Medical Association go on record in favor of the proposition that the organizational structure of a duly constituted medical staff of a non-profit hospital should include items relevant to perpetuation of self government by the medical staff; and be it further

"Resolved, That this resolution be brought to the attention of hospital accrediting agencies for use by them as they review the organizational structure of non-profit hospitals in the State of California."

Your committee recommends that this amended resolution "Do Pass."

Mr. Speaker, I move the adoption of this section of the report.

VICE-SPEAKER BAILEY: It has been moved and seconded that the amended resolution "Do Pass." Is there any discussion? Hearing none, all those in favor will say "aye." Opposed?

... There being no discussion, the motion was put to a vote and it was unanimously carried. ...

VICE-SPEAKER BAILEY: This section is adopted.

DR. HADLEY: Resolution No. 21 is introduced by J. Needham Martin, representing the San Bernardino County Medical Society.

This resolution concerns the American Medical Association entertainment expenses.

Your committee agrees in principle with this resolution and recommends "Do Pass."

Mr. Speaker, I move the adoption of this section of the report.

VICE-SPEAKER BAILEY: It has been moved and seconded. Is there any discussion? All those in favor will say "aye." Opposed?

... There being no discussion, the motion was put to a vote and it was unanimously carried. ...

VICE-SPEAKER BAILEY: This section of the report is adopted.

DR. HADLEY: Resolution No. 22, introduced by Burt L. Davis, representing the Santa Clara County Medical Society.

Your committee agrees in principle with the resolution but would like to amend the first three paragraphs of the resolution, by adding the words "confusion and uncertainty" in the first two paragraphs and the phrase "in the interest of better administration of the program" in the third paragraph. These paragraphs would then read as follows:

"WHEREAS, There has been great dissatisfaction, confusion and uncertainty with the existing definition of a crippled child, as defined in the Crippled Children's Act; and

"WHEREAS, This dissatisfaction, confusion and uncertainty has not been confined to the medical profession, but also was emphasized by the Assembly Interim Committee on Public Health in its report of January 16, 1953 regarding the Crippled Children's Program in California: now, therefore, be it

"Resolved, That the Council of the California Medical Association and the appropriate committees be instructed by this House of Delegates to exercise their good judgment toward efforts to amend the existing definition to make it more satisfactory in the interest of better administration of the program; and be it further—"

The remainder of the resolution remains as mimeographed.

Your committee recommends that this amended resolution "Do Pass."

Mr. Speaker, I move the adoption of this section of the report.

VICE-SPEAKER BAILEY: It is moved and seconded this section of the report be adopted. Is there any discussion? There is discussion. Dr. Sirbu of San Francisco.

DR. SIRBU: Mr. Chairman, I hesitate to oppose this resolution because in principle I am in favor of it, but I would like to call to the attention of the House that on Sunday you passed a resolution which embodies the scope of the resolution now under consideration—in effect you asked for a legal definition of the crippled child and you instructed the Council to use other means to implement this definition and you also went into a number of phases of the Crippled Children's Service as it is administered.

Now by duplicating this you are, I believe, acting unfairly to an agency which in my opinion has made an honest effort during the past few years to seek and to abide by the guidance of the medical profession. I call to your attention the fact there is an Advisory Committee consisting of some twenty physicians in addition to four or five laymen interested in the crippled child that meets at regular intervals with the Crippled Children's Administration.

In the brief time that I have sat on the Advisory Board, my experience is that it is truly representative of this body. It is truly representative of organized medicine. It embodies at least a good portion of the Committee on Public Health that has sat and advised the Administration. Now to continually pass resolutions implying, or with the implication that the Crippled Children's Service is continually doing a bad job I think shows rather bad faith, and I would suggest that you vote this down as unnecessary and as serving no good purpose.

VICE-SPEAKER BAILEY: Thank you, Dr. Sirbu. Is there any further discussion? Dr. Burt Davis.

DR. DAVIS: I had not suspected that I would be called upon to speak to this question but I am happy to be here.

The resolution which you passed on Sunday covered a broad scope. There was much to be said in favor of including the definition as an amendment to that resolution and attempting to pass it at the same time. I did feel, however, and many of those with whom I discussed the matter, that it would be unwise to introduce as extensive a matter as a legal definition as merely an amendment to a resolution which was at that time on the table. And therefore the Reference Committee would have had probably that whole question of Crippled Children's activities referred to it.

So we decided that it would be much better to leave the existing resolution as it was and then to supplement that with a resolution which gives a suggestion for a definition.

Now, the definition of a Crippled Child in the present Code which is purely in the administration of it—it has not been defined by legislative action—the definition in the California Administrative Code, title 17, Section 2901 is that a physically handicapped child is a person under 21 years of age who has physical defects resulting from congenital anomalies or acquired through disease, accident or faulty development.

And then it goes on to say, "The following conditions are reportable:

- "1. Defects of an orthopedic nature, due to infection, injury or congenital malformation.
- "2. Defects requiring plastic reconstruction.
- "3. Defects requiring orthodontic reconstruction.
- "4. Eye conditions leading to loss of vision.
- "5. Ear conditions leading to loss of hearing.
- "6. Rheumatic or congenital heart disease.
- "7. Other disabling or disfiguring deformities."

In other words, the definition merely says that the person who needs care must be under 21 years of age. There is no limitation because the last is all-inclusive.

Now, we felt that the way to approach this matter would be to suggest first that the Council work on a better definition, and as Dr. Carey challenged me the other day to work on a definition for it, naturally I had one prepared which was in this resolution, and this suggested merely that the definition might take this particular form.

The form of this resolution, if you will look at it carefully, goes on in its preamble much the same. There is no desire to utilize the funds which are to be used by the Crippled Children's Administration for cases where there are other funds available. There is no use in squandering the funds on one case where there is no reasonable assurance that there may be improvement in the child. There certainly is no need to squander the funds on conditions where the matter is really relatively trivial or where the disease or the impediment may be very safely and without any danger to the child be postponed until such time as he is earning his own living and able to take care of it himself.

So we felt that the new definition should be or could be that treatment may be afforded when there is reason to believe that such treatment may cure or arrest the condition and when financial hardship prevents adequate care through other than public means or where adequate care cannot be obtained through the usual channels.

It is the purpose of the act to provide assistance to the handicapped child who may be benefited by it, but the act is not to be interpreted in a manner which will dissipate these funds for purposes in which there is no reasonable assurance for the improvement, where other funds are available, when the condition is of a trivial nature and where care may safely be postponed until the time that the child may elect to have the treatment himself.

I don't see that we would in this way be hurting anyone's feelings. Obviously the Public Health Committee on Crippled Children's Services has not had a meeting since last Sunday. It merely means that this, for the files, supplements and assists the Council in its handling of the problem. I think that the two should be considered more or less by the Council as one request from the organization rather than that this is a separate resolution that needs further activity. It is all bound up in one problem, as you well know.

VICE-SPEAKER BAILEY: Dr. Davis, before you leave, the Chair must admit considerable surprise at discovering a few days ago that orthodontia and removal of tonsils are included in Crippled Children. Do your definitions include these?

DR. DAVIS: I think that in this resolution we say that things that are of a trivial nature need not be taken care of, and also we say that the care may be postponed until such time as the child may elect to have the treatment himself. There is adequate provi-

sion in this resolution or in this definition which will give force to the physician members of the Advisory Committee and give them something that they can work on. Certainly the definition as it now stands doesn't mean a thing.

VICE-SPEAKER BAILEY: Thank you, Dr. Davis. Is there further discussion? Then the adoption of this portion of the report stands before you. Those in favor will say "aye." Those opposed?

... There being no further discussion, the motion was put to a vote and it was carried. ...

VICE-SPEAKER BAILEY: It is carried. Proceed.

DR. HADLEY: Resolution No. 23, introduced by Burt Davis, representing the Santa Clara Medical Society.

This resolution deals with hospital accreditation. Your committee agrees with the principle of this resolution and recommends "Do Pass."

Mr. Speaker, I move the adoption of this section of the report.

VICE-SPEAKER BAILEY: It has been moved and seconded that this section of the report be adopted. Is there discussion?

DR. DAVIS: Mr. Speaker.

VICE-SPEAKER BAILEY: Dr. Davis.

DR. DAVIS: I am speaking and taking up a little of your time at this point because the County Medical Society which I represent has instructed our delegation to do everything in its power to present to you one of the problems that we have in Santa Clara County. The resolution was entered because of the fact that we found that when we ran up against an unusual problem, one of the methods whereby this problem could be taken care of was to appeal to the Joint Accreditation Commission for its good offices in looking over the situation.

At that point we found that many doctors, most doctors—I say probably 90 per cent or more doctors—were not fully aware of the Joint Accreditation Commission and the excellent work that it has been doing. Our situation was this—we had in San Jose two community-type hospitals, both run under private auspices, both long revered and respected, having open staffs. Along about 1950 or thereabouts it was decided that funds should be raised for enlargement of one of these hospitals. These funds were obtained by public subscription on a strictly non-sectarian, non-partisan basis. There were members of all faiths represented. There were members of all strata of economic eligibility represented.

And it was at that time repeatedly assured to the County Society and to members of the hospital staff that the hospital would, and to the best of the power of the governing board of the hospital and the ownership of the hospital—the hospital would continue to run as an open staff hospital.

We have at least two letters to that effect which were sent to the staff and which were sent to the staff officers. These funds then were raised by giving the community a moral assurance that this was the type hospital that they were to have. Other funds

were obtained by Hill-Burton money. Other funds were obtained by borrowing from certain banks.

The hospital then was built and up until the middle of last summer no one had any inkling that there was going to be any other type of staff organization. There had been a committee that had been working for two or three years on the By-Laws and Constitution in an effort to set up a new set of By-Laws. These had been gone over several times with the governing board of the hospital and with the organization that owns the hospital. Various changes had been suggested but I don't think that it was any more prolonged or delayed than the labor pains that most Constitution and By-Laws revisions take, and probably in most of the hospitals in which we practice.

In any event, in October or a little before that the administrator of the hospital was changed. The new administrator saw fit to notify the staff that since they had been working for a couple of years without any fruition of their efforts, and since they had voted to repeal or to make new By-Laws that had constituted a repeal of their By-Laws, the interpretation was given by the hospital administrator that the staff was then not operating under any By-Laws.

Well, I don't know whether By-Laws are ever written in any other fashion but any By-Laws that I have ever seen always contain the provision that these will remain in effect until they are replaced by a new set, and certainly that was true in the case of the By-Laws under which this particular hospital was operating. The administrator of the hospital then summarily stated that since you are not operating under a set of By-Laws I have—and the governing board has prepared a set of By-Laws and the ownership of the hospital has prepared a set of By-Laws under which you will operate and I therefore am appointing certain doctors to certain staff appointments. I am appointing certain doctors to be the officers of the staff, the chief, the vice-chief, the secretary and so forth.

This certainly did not constitute a self-governing staff. The staff as it was appointed then from October through to December finally consisted of 26 doctors. Previously there had been in the neighborhood of 250 doctors on the staff. So 90 per cent of them were dispossessed so to speak and were left off as active staff members. Now many of the ones who were left off had been offered courtesy privileges, had been offered associate privileges and had been offered various subsidiary forms of staff membership which might be all right but certainly if a doctor was worth being on the staff certainly his advice should be available in meetings and he should be entitled to vote.

This group of 26 then was enlarged by the first of the year to somewhere in the neighborhood of 50, 51 or 52. And as I say, these men were arbitrarily appointed not by the staff but by the administration without any selection through staff committees, without any request for membership coming from a staff committee. They also were selected in a rather capricious way. There were only two surgeons. There were ten or some general practitioners. There

was only one orthopedist and certain broad areas of medical care were completely overlooked.

This staff then—or the old staff requested that the County Society act in their behalf and they held a meeting at the end of December at which seven or eight members spoke. These eight people were people who were included in the fifty appointed by the hospital administrator. These eight doctors spoke in very gentlemanly fashion and we have a tape recording for anyone who is interested in just exactly what they said, and within 48 hours each received a letter by registered mail, special delivery, which said in effect, "Since you saw fit to stand up and criticize our policies we interpret this that you are not interested in the hospital and in its organization and therefore you are not needed on the staff and you are not any longer a member of the staff."

Certainly this was a capricious and arbitrary method to inflict upon a staff where one should have self-government and responsibility from the doctors.

These doctors, some of them you don't know, you do know two of them, I know, personally as members of the House, Dr. Leon Fox, chairman of our delegation, past president of our society, Dr. Leslie Magoon. There were five past presidents of the County Medical Society in this group. They were men who were well known and whose integrity and ability is absolutely unquestioned.

Dr. R. Stanley Kneeshaw, past president of this organization, past president of our County Society, was not included in the first fifty. (Laughter.) He was the oldest living member of the staff, having been on the staff for thirty years, and he was completely overlooked. So that we felt that things were in a rather sad state of affairs when hospital administrators could dictate to the staff how they should run staff affairs, who they should have as their staff officers, who should be on the staff.

Incidentally, of the fifty there was one man who was put on the staff—I have no objection to him personally—I think he is a splendid doctor, but he had only been in the community something like a month and a half. He hadn't been in the community long enough for us to know him and get him into the County Medical Society but he was selected and Stan Kneeshaw was not.

Now, since January—I have cut an awful lot of detail out from here on. Since January a group of interested citizens representing all faiths and groups of labor organizations, various groups of doctors, all of these people have offered their good services to try and straighten out this problem. The hospital administration remains adamant and says that as far as they are concerned there is nothing to discuss, there is no problem, this is the staff. This is their hospital. This is what they wanted to do and that is what they are going to do, so that is all there is to it.

Therefore, we have prepared the resolution which is before you which points out that the Joint Accreditation Commission has been set up by various bodies and has been set up with the idea not only of improving certain specialty training in hospitals, but also the overall setup of the hospital whether they

have beetles in their flour bins and whether they have abnormalities in their governing boards' thinking, and this Joint Accreditation Commission when we wrote to them sent an inspector out. He went back and reported to the commission on the list which was put out in January, the new list did not include the name of the hospital in question. We felt that here medicine has an opportunity to curtail these abuses which we thought was a little local problem with some hard-headed and some stubborn people involved—and suddenly we found that we got letters from eight different state societies, one asking us for a thousand reprints of a newspaper article that we had prepared. They wanted a thousand reprints at their expense. We found that another state society wrote and said they wanted enough copies for all their committee chairmen to read.

We found numerous county societies all over the United States and we found numerous doctors, very influential ones too, people such as Evarts Graham, writing in and saying, "Now, you simply have an intolerable situation; we hope that you will keep up the fight."

The resolution is to point out that there is this new approved method of certification. We have found that it has been of great assistance to us. We have found that most doctors are not aware of its existence and we earnestly hope that the C.M.A. and the various county societies will spread the gospel so that other doctors who may be presented with the same situation will be offered the same amount of cooperation as we have gotten through the Joint Accreditation Commission. Thank you. (Applause.)

VICE-SPEAKER BAILEY: Thank you, Dr. Davis, for giving us an explanation of something that seemed pretty much unexplainable.

Now then, we will proceed to vote on the adoption of this section of the report unless there is further discussion. All those in favor will say "aye." Opposed?

... There being no further discussion, the motion was put to a vote and it was unanimously carried. ...

VICE-SPEAKER BAILEY: This section of the report is adopted. Proceed, Dr. Hadley.

DR. HADLEY: Resolution No. 25 introduced by William L. Bender, representing the San Francisco Medical Society.

We have amended the resolved portion and have added, after "American College of Physicians" the words "American Academy of General Practice."

In the accompanying letter we have added to the statements of principles item No. 8, which reads as follows:

"8. We suggest that members of the American College of Surgeons be charged with the responsibility of initiating action on a local level."

Your committee recommends that this resolution and the accompanying letter in its amended form "Do Pass."

Mr. Speaker, I move the adoption of this portion of the report.

VICE-SPEAKER BAILEY: It has been moved and seconded that this portion of the report be adopted. Dr. Hodges, do you care to speak to the question?

DR. HODGES: I wish you would turn to your resolution, to the letter following it, and I wish to make an amendment.

VICE-SPEAKER BAILEY: This is page 7, the mid-portion—the last portion of page 7, is that correct, Dr. Hodges?

DR. HODGES: No, this will be on page 9.

VICE-SPEAKER BAILEY: Page 9.

DR. HODGES: If you will turn to the last paragraph of the letter, the third sentence, it reads at present as follows:

"We assure you of our wholehearted cooperation in carrying out any plans which you may institute."

Mr. Speaker, I move you that after the word "any" we insert the word "acceptable."

VICE-SPEAKER BAILEY: Dr. Hodges, wait a minute, let's just find that exactly, will you? What paragraph is that? Page 9, resolution No. 25.

DR. HODGES: That is the last paragraph of the letter.

VICE-SPEAKER BAILEY: Yes.

DR. HODGES: On page 9, and you will see that the third sentence reads as follows:

"We assure you of our wholehearted cooperation in carrying out any plans which you may institute."

I propose, sir, that we add the word "acceptable" after the word "any."

VICE-SPEAKER BAILEY: Thank you. I have it. Is there any further debate?

DR. DAVIS: Mr. Speaker.

VICE-SPEAKER BAILEY: Yes.

DR. DAVIS: I hope this is the last time I will be up here, this session at least. I find here that although I am totally in accord with the principles voiced by this letter that there are certain inaccuracies in it that make it unacceptable to me.

On page 8, if you will go back to the preceding page, the paragraph which is listed as No. 2 at about the middle of the page. The second sentence in that paragraph says "make hospitals responsible for misdeeds of staff physicians." That would put it right back to the spot I was just talking about a few minutes ago. I am sure that Dr. Bender intended to mean, make hospital staffs responsible for the misdeeds of staff physicians, because if you suggest that the Joint Accreditation Commission make the hospitals responsible the obvious thing is that the hospital is going to say, "All right, we will appoint five doctors and they will be the staff and we are not going to bother to have anybody else."

The whole letter contains some statements which are a little bit antagonistic, I think, and I should like to amend this resolution to the effect that the Council send—or the president of the society send an appropriate letter to these organizations which have been listed, but I think that the exact phraseology of

that letter should be left to the officer who writes it and signs it with the approval of the Council. That being an amendment, I would like to speak slightly to the point of saying I think that when we get to dotting the *i*'s and crossing the *t*'s and making the commas in a letter which is to go from one of our officers, if we have confidence enough in the man to raise him to that exalted position, I think we should have confidence enough in him that he will write the kind of letter that we expect him to write.

So, therefore, the exact verbiage should be left to the signator of the letter.

VICE-SPEAKER BAILEY: Now then, Dr. Davis, is that a motion to amend to refer the letter to the Council?

PRESIDENT GREEN: May we read that whole section two please, the whole thing? Dr. Davis has just read one part there.

VICE-SPEAKER BAILEY: Dr. Davis has moved to refer the entire letter to the Council, is that correct, for appropriate action? It is a three-page letter.

DR. DAVIS: Let us say that instead of having the resolution read, "Resolved, that the accompanying letter," say, "Resolved, that an appropriate letter," which develops the method by which this and that can be done, be written and sent by the President of the California Medical Association. In other words, the specific amendment would be to replace the words "the accompanying" by the words "an appropriate," and secondly to delete the letter which is mimeographed before you.

VICE-SPEAKER BAILEY: There is an amendment. Is there a second to that amendment?

... The amendment was variously seconded. ...

VICE-SPEAKER BAILEY: Seconded that an appropriate letter be sent and delete the letter. There is a second to the amendment. Is there any discussion on this particular problem, the amendment? All those in favor will say "aye." Opposed?

... There being no further discussion, the motion was put to a vote and it was carried. ...

VICE-SPEAKER BAILEY: So ordered.

Now, Dr. Green, do you expect to speak to your point?

PRESIDENT GREEN: It doesn't seem quite clear to me. In reading number two on page 8 I will read the whole thing:

"Notify accredited hospitals, and those who apply, that infraction of these rules will cancel your approval automatically. Make hospital staffs responsible for misdeeds of staff physicians, in fact of all professional personnel."

Does that mean that the medical staff is going to be critical of all professional personnel in a hospital? There are a lot of people in that hospital who are professional who are not doctors. That is the way it reads and the staff is going to be responsible for all professional people in the hospital.

DR. DAVIS: Point of order. That has been deleted.

VICE-SPEAKER BAILEY: That part has been deleted. Now, is there any further comment on this? Otherwise, we will pass Resolution 25 as amended.

DR. BENDER: Mr. Chairman.

VICE-SPEAKER BAILEY: Yes, Dr. Bender.

DR. BENDER: Mr. Speaker, members of the House: Since I am responsible for this I just want to say a few words about what led up to it. It was intended, number one, to spell out to the Board of Governors of the American College of Surgeons a way to curb the practices which they have condemned so loudly, and two, it was to put a brake on the periodic blasts that meet the public that do us no end of harm.

This letter was sent by the officers of the San Francisco Medical Society about last December, I think it was, shortly after the *Collier's* blast, and it received some favorable letters from the American College of Surgeons and officers of the American Hospital Association, both of which reprinted the letter in their official organs. I have no desire to try to pressure through something this way. I have no desire to intrude on any of the functions of the offices. I do think that a very strong letter should go from this organization along these lines in order to make the American College of Surgeons responsible to the rest of the medical profession for the things they say about us and what we do without offering any positive means of correction.

VICE-SPEAKER BAILEY: Thank you, Dr. Bender. We will then go back to the original resolution. Any further discussion on it as amended. There is none. All those in favor of the resolution say "aye." Opposed?

... There being no further discussion, the motion was put to a vote and it was unanimously carried. ...

VICE-SPEAKER BAILEY: Dr. Hadley, will you continue, please?

DR. HADLEY: Resolution No. 26, introduced by William L. Bender representing the San Francisco Medical Society. The title of this resolution was left off the mimeographed report again and it is on the Action Committee.

Your committee agrees that an Action Committee should be named by the Council and no matter how set up, whether within an established committee or autonomously, it should include one or more members from the Medical Services Commission.

Your committee recommends that this resolution "Do Pass."

Mr. Speaker, I move the adoption of this portion of the report.

VICE-SPEAKER BAILEY: It has been moved and seconded that this portion of the report be adopted. Is there discussion?

Dr. Sherman, from San Francisco.

DR. SHERMAN: Mr. Speaker, members of the House of Delegates: In order not to dilute the functions of the activities of the Medical Services Commission or any other established committee which may be working along these lines, we feel that there should be an amendment placed to this particular

suggestion of Reference Committee No. 3. We believe the amendment should be as follows:

"*Resolved*, That the House of Delegates recommend that the Council of the C.M.A. set up this new Action Committee as defined in Resolution No. 26 as a separate committee."

Or if you want to use the word autonomous as acceptable, and also recommend that there be on this committee members of the Medical Services Commission and any other existing committees for purposes of continuity, guidance and advice.

VICE-SPEAKER BAILEY: Do you happen to have that written out? If you will turn that in to the Secretary—Do you have a copy of that there?

DR. SHERMAN: It is a very rough one. I will give you the rough one.

VICE-SPEAKER BAILEY: We have then the amendment proposed by Dr. Sherman. Dr. Hadley.

DR. HADLEY: May I speak?

VICE-SPEAKER BAILEY: Yes, you may.

DR. HADLEY: I do not believe this amendment would be necessary because in the first resolve it specifically states that an authority be created in an existing committee if practicable or in a special committee composed of seven individuals appointed by the Council, and of course responsible to the Council, et cetera.

VICE-SPEAKER BAILEY: And we have an amendment before the House. Is there a second to it? Dr. Sherman's amendment, is it seconded?

A MEMBER: Second.

VICE-SPEAKER BAILEY: There is a second. Any further discussion? Dr. Teall.

DR. TEALL: I simply ask that the amendment be defeated and I ask that because it seems to me that as recommended by the Reference Committee the matter is left to the Council for determination of who the actual committee shall be. In the near future you will hear more about the proposed program which the Council is attempting to implement in response to resolutions which you have already passed this afternoon. Dr. Sherman will, as you have heard a little earlier, be a member of that Council and will have every opportunity to make his suggestions at that time as to the autonomy of the Action Committee. I agree with the chairman of the Reference Committee that it is totally unnecessary for this House of Delegates to spell out the organization of that Action Committee and that it might properly be left in the responsibility of the Council which will be charged with other actions in this field.

I therefore urge you defeat the amendment.

VICE-SPEAKER BAILEY: Dr. Sherman, in view of this further information, do you care to have the motion put to the House?

DR. SHERMAN: Yes, sir.

VICE-SPEAKER BAILEY: You do? Any further discussion? All those in favor of the amendment will then say "aye." Opposed?

... There being no further discussion, the motion was put to a vote and it was lost. ...

VICE-SPEAKER BAILEY: The amendment is defeated.

We then proceed back to the original resolution. Any further debate on the original resolution as amended? All those in favor it do pass say "aye." Opposed?

... There being no further discussion, the motion was put to a vote and it was unanimously carried. ...

VICE-SPEAKER BAILEY: It is passed and adopted.

DR. HADLEY: Resolution No. 28, introduced by Howard C. Miles, representing Monterey County Medical Society.

This resolution deals with the illegal use of medical preparations. Your committee agrees with the principle of this resolution and recommends "Do Pass."

Mr. Speaker, I move the adoption of this portion of the report.

VICE-SPEAKER BAILEY: Moved and seconded that this portion of the report do pass. Is there any discussion on it? Dr. Gibbons.

DR. GIBBONS: Since this resolution deals with the matter of the Board of Medical Examiners, they might well be interested in it because if an unlicensed person prescribes medications, I think that it would be wise to amend the motion to have a copy of this resolution sent to the State Board of Medical Examiners, and I so move.

VICE-SPEAKER BAILEY: The amendment, then, Dr. Gibbons, is there a second?

A MEMBER: Second.

VICE-SPEAKER BAILEY: The amendment then reads:

"*Resolved*, That a copy of this be sent to the California State Board of Pharmacy and the California State Board of Medical Examiners."

Any discussion? Those in favor of the amendment will say "aye." Opposed?

... There being no further discussion, the motion was put to a vote and it was unanimously carried. ...

VICE-SPEAKER BAILEY: The amendment is carried. Now the original motion as amended. All those in favor will say "aye." Opposed?

... There being no further discussion, the motion was put to a vote and it was unanimously carried. ...

VICE-SPEAKER BAILEY: Carried, and so ordered. Dr. Hadley.

DR. HADLEY: I may add that Dr. Gibbons is a member of the California State Board of Examiners. He can take his copy home with him. (Laughter.)

Resolution No. 29, introduced by Howard C. Miles, representing Monterey County Medical Society. The title of this resolution was left off the mimeographed copy; it is on the restricted licensure of nonmedical groups.

Your committee has made an addition to the first sentence of the resolved portion, reading as follows:

"*Resolved*, In the interest of public health and welfare, the House of Delegates ..."

With this addition, your committee recommends "Do Pass" in the amended form.

Mr. Speaker, I move the adoption of this section of the report.

VICE-SPEAKER BAILEY: Moved and seconded this section of the report be adopted. Is there any discussion? There being no discussion, those in favor will say "aye." Those opposed?

... There being no discussion, the motion was put to a vote and it was unanimously carried. ...

VICE-SPEAKER BAILEY: It is carried and so ordered.

DR. HADLEY: Resolution No. 30, introduced by Roderick A. Ogden, representing the Kern County Medical Society.

This resolution deals with a student loan fund. We have found it necessary to rewrite this resolution as follows:

"WHEREAS, The American Medical Association and the California Medical Association have expended considerable effort to establish favorable public relations between medical students and organized medicine; and

"WHEREAS, The cost of medical education, in tuition, fees and subsistence, has increased to such a degree that a number of medical students who offer promise of being excellent physicians are either denied that opportunity or greatly hindered in its fulfillment; and

"WHEREAS, Concrete evidence of the interest of organized medicine in the problems of medical students, particularly in the rendering of financial aid, would undoubtedly be a very strong factor in establishing good relations between students in training and organized medicine, and would also allow some students, who in later years would reflect credit and honor on medicine, to complete their education; therefore, be it

"Resolved, That the Council of the California Medical Association investigate, or appoint a committee to investigate, the possibility of establishing a Loan Fund."

Your committee recommends that this amended resolution "Do Pass."

Mr. Speaker, I move the adoption of this portion of the report.

VICE-SPEAKER BAILEY: It has been moved and seconded that this portion of the report be adopted. Is there a discussion? Dr. Farthing.

DR. FARTHING (San Mateo County): I am in full accord with the resolution as amended by the committee but I believe that its usefulness can be further enhanced and I would therefore like to submit the following amendment. I would like to add a few whereases. So therefore at the bottom of the last whereas in the amended portion of the resolution I would like to have the wording changed so as to omit "Therefore be it" and start off, "And, also,

"WHEREAS, It is well known that many young doctors with excellent training and ability are discouraged from entering private practice of medicine

by debts, financial obligation of starting an office and maintaining a home; and

"WHEREAS, This financial insecurity lends itself to the easy exploitation of this group by certain organizations which may offer"—(laughter)—"an enticing and seemingly adequate fixed salary; and

"WHEREAS, Such organizations by their exploitation tend to captivate this highly trained young medical talent in localized areas, thus depriving the people in many areas of the services of such highly trained doctors; and

"WHEREAS, Such financial insecurity and exploitation tends to frustrate the ultimate ambitions and aims of the young physicians to enter the private practice of medicine in a community of their choice; now, therefore, be it

"Resolved—"

And I would like to change the resolved portion of the amended resolution:

"Resolved, That the Council of the California Medical Association proceed without delay to the establishment of a Loan Fund, the purposes of which shall be:

"1. To aid needy and worthy medical students duly accepted for registration in Class A California medical schools,

"2. To aid recently graduated doctors of Class A California medical schools in the establishment of their own private practice; and be it further

"Resolved, That inasmuch as young doctors are unusually good credit risks, this fund be administered very liberally as to time and interest."

VICE-SPEAKER BAILEY: Thank you, Dr. Farthing. May we have that amendment? You are not going to amend on frustration, I guess. (Laughter.) Is there any second to Dr. Farthing's amendment?

... The amendment was variously seconded. ...

VICE-SPEAKER BAILEY: There is a second. Dr. Lum.

DR. LUM: Mr. Speaker, I think that this should be recognized as an expression of opinion of Dr. Farthing. I doubt whether the adoption of his amendment is necessary. I am quite sure that the Council would take cognizance of his remarks.

VICE-SPEAKER BAILEY: Thank you, Dr. Lum. Dr. Ogden, Kern County.

DR. OGDEN: As one of the alternates of this resolution we spent a certain amount of time working this up. We considered at first making it highly specific as to the loans, the type of loans, how long they would be in effect and who would get them. As we worked more and more on it we kept deleting things. We considered at first including the young doctor starting in practice. We considered particularly the problem of financing the resident in training and the intern in training, and we finally decided that if we could get this started, if we can get a committee appointed by the Council that it would be up to the Council and the committee from then

on to decide the extent and the administration of this fund.

VICE-SPEAKER BAILEY: Thank you very much, Dr. Ogden. Is there further discussion on the amendment? The vote is now on the amendment as to whether we shall add Dr. Farthing's portion of the report. All those in favor will say "aye." All those opposed?

... There being no further discussion, the motion was put to a vote and it was lost. ...

VICE-SPEAKER BAILEY: The "noes" have it. The amendment is lost but that still doesn't mean, Dr. Farthing, that we aren't all heartily in favor of it. (Laughter.) That isn't prejudiced. In other words, we don't want to tie the hands of the Council.

Now, to get back to the original resolution, No. 30, any further discussion on it? There being no further discussion, all those in favor will say "aye." Opposed?

... There being no further discussion, the motion was put to a vote and it was unanimously carried. ...

VICE-SPEAKER BAILEY: Passed and so ordered. Now, Dr. Hadley.

DR. HADLEY: I wish again to thank Drs. Weyrauch and Randall for their splendid cooperation in preparing this report, and I would also like to thank Mr. Gillette and Mr. Hap Hassard for their help.

Mr. Speaker, I move the adoption of this amended report as a whole.

VICE-SPEAKER BAILEY: It has been moved the amended report as a whole be adopted. Is there any discussion? All those in favor will say "aye." Opposed?

... There being no discussion, the motion was put to a vote and it was unanimously carried. ...

VICE-SPEAKER BAILEY: The report is adopted, and may I take this opportunity to offer thanks to Dr. Carl M. Hadley of San Bernardino, Dr. Helen Weyrauch of San Francisco and Dr. Samuel Randall of Santa Cruz for long arduous labor and a very excellent report. (Applause.)

...The Chair was assumed by Speaker Charnock....

SPEAKER CHARNOCK: The next order of business naturally will be the report of Reference Committee No. 4. No business was sent to Reference Committee No. 4, so they were put in conjunction with C.P.S. Reference Committee, and you will now hear from the chairman of the C.P.S. Reference Committee. Dr. Paul Foster of Los Angeles.

REPORT OF C.P.S. REFERENCE COMMITTEE

DR. PAUL FOSTER: Your C.P.S. Reference Committee, consisting of myself, Dr. Dan Kilroy and Dr. Fred Olson, has been fortunate to have the services of Reference Committee No. 4, consisting of Drs. Thomas LeValley, Dr. Dorothy Allen and James E. Feldmayer.

The first item referred to your committee was the report of Dr. Francis T. Hodges, president of the

C.P.S. Board of Trustees, who on Sunday reported the progress of California Physicians' Service to the House of Delegates.

The committee feels that it was an excellent report.

On the whole, Dr. Hodges' statement reflected optimism among the trustees and the administration regarding the present and future effectiveness of C.P.S. as the medical profession's instrument to make health insurance work better for more people.

Encouraging progress was reported on new contracts, new membership, financial condition, professional and public relations, administrative efficiency, the development of indemnity type insurance.

We can all share in the feeling of satisfaction over C.P.S.'s heartening achievements on these many fronts. But the committee feels that we should not bask in our own satisfaction so long that we fall asleep to the danger signals contained in Dr. Hodges' report.

We refer to the section regarding C.P.S. income ceiling and closed panel competition.

While making it clear that the income ceiling decision is one for the profession and not for C.P.S., Dr. Hodges' report also makes it abundantly clear that C.P.S. is selling—and will sell in the future—few significant groups while the income ceiling remains at \$4,200.

Dr. Hodges also states, and we quote:

"Where doctors have been active in the solicitation of any large group in competition with closed panel plans without an income ceiling, they have been continuously reminded by group leaders that the income ceiling must be raised to \$6,000 or eliminated. In San Pedro the income ceiling was eliminated, and for students in the new branch of the University of California at Riverside, in order that the groups involved might have the benefit of the services of doctors in the private practice of medicine."

This committee feels that what Dr. Hodges has reported—as well as what we have heard from countless sources during our consideration of the various C.P.S. resolutions—adds up to two things:

1. An increase in the C.P.S. income ceiling (as proposed by the C.M.A. Council in Resolution No. 5) on a local option basis, is imperative, if C.P.S. is to remain an effective, competitive instrument of the medical profession in the field of prepaid health insurance.

2. A high degree of unity is essential within the medical profession in supporting California Physicians' Service.

California Physicians' Service is a successful, going concern. It is painstakingly building public confidence and support for its services and the profession operating it. The success of its future activities depends, however, to a large extent on the policies we tell it to follow and the degree of support and unity we give those policies.

Mr. Speaker, I move the acceptance of this portion of the report.

SPEAKER CHARNOCK: This portion of the report has been moved and seconded. Is there any discussion?

DR. BATZLE: Mr. Chairman.

SPEAKER CHARNOCK: Doctor.

DR. BATZLE: I am Dr. Batzle from Riverside County. In the large letters is a report that there is no income ceiling in the Riverside contract with the University. I feel that that implies that the doctors of Riverside County feel that there should be no income ceiling. I would like to make it clear to this House that that happened inadvertently. It was a matter we had overlooked, and also we overlooked it for the simple reason that we did not think any student in the University would come under that income ceiling. Thank you.

SPEAKER CHARNOCK: Thank you, Dr. Batzle.

Will you proceed, Dr. Foster? Is there any other discussion on this section of the report? Those who are in favor of this section of the report will signify by saying "aye." To the contrary?

... There being no further discussion, the motion was put to a vote and it was carried. ...

SPEAKER CHARNOCK: It is accepted.

DR. FOSTER: Resolution No. 5. You have it before you so I won't reread it. Your Reference Committee is fully cognizant of the growing public need for greater certainty of coverage for the cost of doctors' services. Many years of study have gone into this complex problem, and many methods of meeting the public need have been suggested. Apparently there is only one proven and immediately available vehicle to meet the needs of the various areas in these rapidly changing times—C.P.S. with a raised income ceiling. We are in accord with the action of Reference Committee No. 3 in recommending the long-range solution proposed by the Medical Services Commission.

Physicians have already established a number of plans of subscriber groups meeting the needs in their community and guaranteeing freedom of choice of physicians for the providing of methods of payment of the costs for medical, surgical and hospital care.

Inasmuch as a substantial increase in the number of local programs beyond those already adopted would greatly complicate the situation, therefore unified action is desired.

Your committee underlines the importance of doctors in neighboring areas respecting the agreements of those counties adopting this permissive plan to meet local conditions. The medical profession cannot be placed in a position of selling a plan that will not be accepted in the outlying districts, where the public may feel they are being discriminated against or losing out because of buying that particular plan.

Your committee feels that due to the trends of the times, it is desirable to make it possible for local areas to adopt an income ceiling of \$6,000.

Raising the income ceiling to \$6,000 in those areas where it has been requested will make possible the enrollment of state-wide and nation-wide groups.

Due to the lack of uniformity of benefits, it is difficult to enroll large groups of employees where only a portion qualify below the ceiling.

The committee was impressed by the concrete evidence of the profession's ability and its willingness to take the initiative in meeting current needs and trends for certainty of coverage, and the freedom of the patient to choose his own personal physician.

There is no single solution to the problem. The free enterprise system will guarantee that competing kinds of medical care insurance will continue to operate.

Your committee emphasizes the fact that this is a permissive resolution, and that its adoption will not result in a state-wide raise in the income ceiling. The higher income ceiling will become effective only in those societies where a majority of the members desire it and vote for it.

Your committee was just informed that Dr. Francis J. Cox's subcommittee of the Medical Services Commission has reported suggested changes in the fee schedule based on the \$6,000 income ceiling to the Council of California Medical Association. The Council has approved the suggested changes.

Your committee recommends that Resolution No. 5 "Do Pass."

Mr. Speaker, I move the acceptance of this section of the report.

SPEAKER CHARNOCK: It has been moved and seconded that this section of the report be accepted. Is there any discussion? All those in favor of the section—

Dr. Sirbu of San Francisco.

DR. SIRBU: Mr. Speaker, members of the House: It is a little surprising to me that an item of such importance and such widespread discussion should call for such delayed action by anyone discussing this. It may be that further discussion will come out later when other resolutions are discussed. But in effect, if we take this action we are going to establish a principle that I think is going to affect the practice of medicine in California from here on. Now, earlier this afternoon this House passed unanimously Resolution No. 3 which reads to the effect:

"Resolved, That the California Medical Association proceed with vigor in the study, development and implementation of the Usual Fee Indemnity Plan."

That action was taken presumably because the majority of the delegates here in assembly agreed with the report submitted by the Medical Services Commission and agree in general with the Waterson report on which much of it was based. It is our feeling in the San Francisco delegation, and I think I speak for the vast majority present, that you can't develop two of these plans immediately and implement them both. There is sufficient evidence that if you are really talking about local option we should know what we are talking about.

In San Francisco, and I am sure there are other counties that feel the same way, if we desire on a local option basis to raise the ceiling to \$6,000, and

there is strong sentiment in our county to do that, we also feel that we should have the local option to determine what fees our members should operate under on the \$6,000 level. It has been amply stated that when you raise the level to \$6,000 you will then take in sufficient numbers so that you will have between 87 and 90 per cent of the people who are seeking this type of insurance. When you do that, of course, you are setting a pattern for the practice of medicine in the community in which you are residing and practicing.

A little later on a plan will be suggested whereby we think true local option will be implemented. We feel that the local option submitted here will have severe implications in those communities where the cost of living and the cost of operations will militate against accepting the type of fee schedule that C.P.S. can write on a service plan on a state-wide basis.

We recognize the fact that it would be terrifically difficult to write any type of insurance on a state-wide basis dealing with 15, 20 or 25 fee schedules. On the other hand we submit that those of us living and practicing in an urban area would find it impossible to continue operations on a fee schedule that suits the entire state when you raise the ceiling to include up to 90 per cent of your practice.

We recognize, all of us, that when we undertook to support C.P.S. we were offering something to the low income level group. Those of us in urban communities where the cost of operation is high were willing to continue on that basis, but we felt that those that were able to pay the private fee should be willing after prior discussion to pay the difference between that low level fee and the usual fee that that doctor charges. That principle, I think, should be perpetuated because if you abolish that principle leaving some 10 per cent of the population only uncovered, then you have set a pattern which you will have difficulty operating under.

I can point out that we have been under negotiation with union leaders and with insurance carriers for a considerable length of time. We have established in San Francisco a set of fees which we think is applicable. It is under continual revision and we are meeting the threat of closed panels under this type of revision. But if you set the pattern on a state-wide basis, why then you are going to tie our hands in negotiation with others. We can't give one deal to C.P.S. and another deal to Blue Cross or an indemnity insurance carrier.

In our area some 75 per cent of the union labor contracts are still being written by indemnity carriers and solving the problem of this group to a great extent notwithstanding the fact there have been some inroads. When these contracts come up for negotiation again we will have a voice in it as we have when C.P.S. and another carrier deal for the indemnity group. Therefore, by this publicity and this action you are setting the pattern not only for C.P.S. contract but for any other insurance carrier contract, and that, may I submit, is not true local option because our hands will be tied by the overwhelming reaction to this on a public relations basis.

It is our opinion that, and I am leading up to what will come on following me, that on a service basis you can't go beyond a \$4,200 limit. The minute you do that you are running into all of the implications I mentioned. If you are going to cover, and we want to cover those up to \$6,000 and perhaps more, then it must be on an indemnity basis which brings us back to the issue at stake, do we want a service or do we want an indemnity proposition for those beyond the semi-indigent or the low income group? Therefore, Mr. Chairman, I would take this opportunity to urge this House to vote down Proposition No. 5 at the present time. (Applause.)

SPEAKER CHARNOCK: Dr. Sherman, San Francisco.

DR. SHERMAN: Mr. Speaker and Fellow Delegates: The San Francisco delegation has requested me as its president to impart to you its views as to a substitute resolution for this Resolution No. 5, based purely on their own convictions that the adoption and implementation of the Usual-Fee Indemnity Plan would be much more to the benefit of the physicians of California and the patients covered under these plans than the plan proposed in Resolution No. 5. Therefore, I submit to you this substitute resolution which reads as follows:

"Resolved, That this House of Delegates recommend the adoption of the \$6,000 annual income ceiling for C.P.S. contracts based on the formulation of the Usual-Fee—"

That is hyphenated, "Usual-Fee Indemnity Plan," as recommended by the Medical Services Commission and as already approved by you as delegates today in Resolution No. 3 which came from Reference Committee No. 3, and that is for immediate implementation on local levels under local option whenever so desired.

SPEAKER CHARNOCK: Is there a second to that amendment?

A MEMBER: Second the amendment.

SPEAKER CHARNOCK: It has been moved and seconded that we amend this passage of the report by substitution of this amendment. Is there any discussion to this amendment?

DR. SHERMAN: Mr. Chairman, may I also state that this is only a substitute for Part 1 of Resolution No. 5, that we leave in Sections 2 and 3 as unamended.

SPEAKER CHARNOCK: This resolution is a substitute amendment for Part 1, Dr. Sherman. Part 1?

DR. SHERMAN: That is correct, sir.

DR. HARRINGTON (San Francisco): I should like to speak in favor of this substitute motion or resolution. You have all heard the report and read the report of the Medical Services Commission which is based on a careful and continued study over a long period of time of a very complex problem. They want and recommend the Usual-Fee Indemnity Plan and this delegation has gone on record as favoring indemnity plans of health insurance by creating a corporation within C.P.S. for the purpose of imple-

menting such plan. This is a no-holds-barred fight with closed panel capitation plans in this country and it is my considered opinion that the private practice of medicine with a free choice of doctor and of insurance plan by the patient cannot compete in an economic sense with such plans.

Only indemnity plans which can be made actuarially sound can compete with such a closed panel group and still maintain the standards of medical care to which the public has become accustomed and to which it is entitled.

A service plan adopted by this delegation which binds the component county societies as does this original motion, not the substitute, is unfair to the individual doctor and to the local societies in that it gives them no real self-determination in the matter of medical economics. The adoption of the Usual-Fee Indemnity Plan as developed by the Medical Services Commission would solve this problem of local option in a very simple manner and would leave each individual doctor and each county society completely free to solve its own economic problem as he or it saw fit.

We must be the masters of our own destiny. When we engage in competitive practices with closed panel capitation plans by hastily conceived and clumsily executed service plans we begin the process of undermining the standards of care in medicine to which we are dedicated, and what is worse, we cut the standards in medicine for those who will follow us.

It has been argued that social trends will dictate our policies and our standards in any case, and that we should bow with the hurricane. With this philosophy I disagree and I urge you not to accept it.

If we must go down, if we must inevitably accept the lower standards of medical care which will inevitably result with competition from closed capitation plans of medical service, let us at least do so with our heads erect and not in the process of cringing hysteria. (Applause.)

SPEAKER CHARNOCK: Dr. Teall, you wish the floor? You are speaking to the amendment?

DR. TEALL: Yes, sir.

SPEAKER CHARNOCK: Correct.

DR. TEALL: I apologize for taking up the amendment, sir, but I didn't understand it when it was read and I wanted an opportunity to read it, and I confess reluctantly that having read it five times I still don't quite know its import. I want to thank Dr. Sherman and Dr. Harrington for the very able exposition of the underlying philosophy of the Usual-Fee Indemnity approach to the problems at hand. There has been some question in the past few days as to my own personal attitude about this introduced resolution. I would like to clarify that at this moment by saying that I wrote it. I presented it to the Medical Services Commission and recommended its adoption there which was done.

I then presented it to the Council and recommended its adoption there, which was done. And I take the further step in recommending its adoption by the House of Delegates here. I would like to

clarify why its adoption is recommended and what it accomplishes.

It is probably totally unnecessary because nearly all of the things which are embraced in this resolution, No. 5, have already been approved by the House of Delegates and in certain parts of the state are in existence. There is already in one sizable branch of one of our county medical societies a plan in operation underwritten by California Physicians' Service in which there is no income ceiling and in which that point is widely advertised to the public.

The fee schedule existing under that plan is the existing fee schedule that applies on the rest of the state in its service operations. This simply says that wherever a county feels the need to have such types of service coverage, wherever any county group desires this approach to its problem, they have the privilege of requesting it and C.P.S. is asked to provide it for them and in order to make good that coverage for individuals who live within that county or who may seek medical care elsewhere, the physician members of C.P.S. are asked to waive the service ceiling up to \$6,000 for individuals who do hold that contract.

This is all that is provided, and may I point out again as was pointed out by Dr. Foster, that this is not a recommendation, an urging, a desire, a forcing, or any other such compulsive term that any county society request or adopt a \$6,000 income ceiling under its C.P.S. service operations.

We tend to become confused. C.P.S. is offering both service and indemnity. We are not in any sense attempting to limit C.P.S.'s indemnity operations and I think we must be careful in the future to make it very clear that we are talking only about the service operations which are the only operations in my mind which require an income ceiling. For this reason I am not able to understand clearly the resolution introduced as an amendment by Dr. Sherman which I will read again for you:

"That this House of Delegates recommend the adoption of a \$6,000 annual income ceiling for C.P.S. contracts based on the formulation of the Usual-Fee Indemnity Plan as recommended by the Medical Services Commission and for immediate implementation."

An indemnity plan is not built on a service ceiling. A service contract requires a ceiling if we are going to limit it at all. An indemnity plan envisions that there will be no ceiling.

Now, any county society group, as Dr. Sherman and as Dr. Harrington have pointed out to us, is completely at liberty to agree with any beneficiary group that its members will abide by any level of indemnity which they decide to be a fee schedule appropriate to that community, and this is the basis as I understand it on which San Francisco has been progressing to this moment. I do not see the necessity of an income ceiling established on a state-wide basis in C.P.S. contracts wherein on an indemnity basis based on the Usual-Fee Indemnity Plan because I am unable to see the compatibility of these two posi-

tions, I recommend to you the defeat of the amendment as proposed. (Applause.)

SPEAKER CHARNOCK: You have heard the discussion directed to the amendment. Are you ready to vote upon the amendment.

A MEMBER: Question.

SPEAKER CHARNOCK: Those who are in favor of the amendment will signify by saying "aye." To the contrary?

... There being no further discussion, the motion was put to a vote. ...

SPEAKER CHARNOCK: The Chair is in doubt. Those who are in favor of the amendment will please stand.

... There was a standing vote. ...

SPEAKER CHARNOCK: Will you be seated, gentlemen? Those who are opposed to this amendment please stand.

... There was a standing vote. ...

SPEAKER CHARNOCK: Will you be seated, gentlemen? The amendment has lost.

Is there any more discussion upon Resolution No. 5?

DR. BULLOCK: Mr. Chairman.

SPEAKER CHARNOCK: Dr. Bullock.

DR. BULLOCK: Gentlemen, I would like to call to your attention a section which was previously adopted at the top of page 2 which says: "A high degree of unity is essential within the medical profession in supporting California Physicians' Service."

I would also like to call your attention to a meeting which occurred in Yosemite at which an important group within this organization voted as to whether they would resign from C.P.S. in a body. The universal opinion, I believe, in that group was that they were being discriminated against. They were not receiving fair play, C.P.S. was not being conducted in a way which would provide the beneficiary with a maximum and the best type of medical service, and that they were getting a little bit unhappy about it.

Now I was one of those that did not vote for separation and I am still a member of C.P.S. and I am still a member purely and only because I feel that I always want to do my part for the support of the organized approach to the problems. I do it, however, at a very great loss to myself and I think that this body is going to have to recognize when it starts increasing the ceiling the fact that there is a major and an important group known as practitioners of internal medicine which cannot survive, which will not survive in my opinion under the present way in which C.P.S. is conducted.

The reason for the unhappiness of this group is very simple. We practice in a certain way. We work on the thesis that we spend a long time with each of our patients. We go into extreme detail in taking a history and doing a physical and making a diagnosis, and we find that when we know what is wrong with the patient their efforts—therapeutic efforts—require relatively little time.

We do not go in for repeated injections or treatments. We see our patients very infrequently normally, a patient comes in and spends a full hour at least, comes back for another half hour, considerable amount of laboratory work is done. The cost for that is there, of course, and the patient is then presented with a complete, thorough, exhaustive diagnostic study representing the type of medicine which we should be proud of, is then told, "Oh, no, the services of internists in practicing this way are not covered under C.P.S."

All right then, that patient with, say, hypertension comes back again in two months or three months. That history is thoroughly and exhaustively reviewed, another complete and thorough detailed examination is done, a full thirty minutes is spent with the patient. The therapy is reviewed, it is prescribed, it is gone over in great detail. All the problems are covered. Once in two months is usually adequate. He might be seen again, say, in two months and then in about eight or ten months he develops congestive failure from his hypertension.

He then comes in, is admitted to the hospital, receives exhaustive study, exhaustive treatment and runs up a considerable bill. At that time he is told, "Oh, it is too bad, I am sorry the first cost you some money and you were not covered. You had no visits, six months is all you have and so your treatment from there on for the rest of your life, which is part of the disease for which you were trying to get insurance, is now inoperative and no good."

Basically, C.P.S. does not try to cover the problems that the internists face. Basically it pays him for that second visit, somewhere around \$3.00 for an hour, full half hour for him and his entire staff. That means basically he and his staff, there are two girls working for \$6.00 an hour, assuming that you divide that equally it means that each, he and his staff and his nurses are getting approximately \$2.00 an hour and that is what C.P.S. seems to think an internist is worth and the internist keeps on doing it.

As a representative of one of those who is still stuck behind it despite a very great loss, I am not going to continue with the increase of this fee schedule to—I mean the limit to \$6,000. It is not possible. If this House wants the internists in it, it is going to have to take cognizance of the fact that internists practice a very certain and special way, that they do what we think is the highest and the best type of medicine. We think that if by appealing to the internists, by finding a place for them, we will provide better medical care for this group of people.

In the army, in every other part of the practice of medicine, the services of the internists are fully and completely recognized. It is universally thought that they provide a part of medicine which is a benefit and a value except in C.P.S. I assure you that I will lead a very definite effort among the internists to resign from C.P.S. in a group if this goes up and if some relief for the internists is not received.

I therefore move you an amendment to this to read as follows, after number 3:

"WHEREAS, The present fee schedule does not adequately cover the type of service characteristic of the practice of internal medicine, that beneficiaries either be advised that services of internists are not included under C.P.S. or that the directors of C.P.S. be instructed to immediately develop a method of covering the services of internists for beneficiaries of C.P.S."

SPEAKER CHARNOCK: Dr. Bullock, you are submitting that as an amendment to section 4?

DR. BULLOCK: It would go in as number 4.

SPEAKER CHARNOCK: You are not amending any of the three sections.

A MEMBER: Second.

SPEAKER CHARNOCK: That amendment has been seconded. It is now open for discussion. Dr. Foster.

DR. FOSTER: I think it is generally recognized that the internists and other medical specialties are not adequately covered in C.P.S. We got the Medical Director of C.P.S. into our hearing and asked him about internal medicine and medical specialists and they have promised that they will take nine major illnesses and try it out on a total sum basis for a period of three months to see how it works out. They realize the inadequacies of the medical specialties and medical portion of the program. I think it is only right that we give them an opportunity to try to carry this out.

SPEAKER CHARNOCK: Is there any more discussion to the amendment?

DR. LUM: Mr. Chairman, members of the House of Delegates: I would like to say that the Council this morning passed a resolution requesting the C.P.S. Trustees to carry out the line of endeavor as outlined by Dr. Foster.

SPEAKER CHARNOCK: Dr. Shipman would like to speak to this amendment.

DR. SHIPMAN: I thought you might be interested in the resolution which the Council passed which Dr. Lum referred to. It reads as follows:

"That the Council request that a drafting of fee schedule to be used in conjunction with the proposed \$6,000 C.P.S. income ceiling consideration be given to the provision of reasonable fees for medical treatment of major illness subject to deductible features of C.P.S. contracts and to preventive use, also subject to request for medical reports and selected cases which may be referred to County Medical Society C.P.S. Liaison Committees for review and recommendation."

SPEAKER CHARNOCK: Thanks, Dr. Shipman. Is there any further discussion to the amendment? Are you ready for the question upon the amendment, Doctor?

DR. TEALL: May we have a rereading of the amendment, please?

SPEAKER CHARNOCK: Dr. Bullock, will you restate the amendment?

DR. BULLOCK: I am most pleased to hear that the Council and the other members who have spoken

have recognized the need for this amendment and action. I think, however, the specific statement on the matter by the House of Delegates is most important. If we want unity we must include all groups of the profession in this, and there is very limited room for changes. In other words, to give the internists reasonable recognition and provide their services for the beneficiaries. It is moved that whereas the present fee schedule of C.P.S. does not adequately cover the type of service characteristic of the practice of internal medicine that beneficiaries either be advised that the services of internists are not included under their contract or that the directors of C.P.S. be instructed to immediately develop a method for covering the services of internists for beneficiaries of C.P.S.

SPEAKER CHARNOCK: Thank you, Dr. Bullock. Dr. Teall, are you discussing this matter?

DR. TEALL: Yes, sir. I have absolutely no quarrel with the principles involved or the amendment suggested. I would only like to suggest that it is not a proper amendment to the particular resolution under discussion at this moment.

If you will glance ahead in your C.P.S. Reference Committee report you will find on page 5 Resolution No. 13 which concerns exactly this problem and which I submit is the proper place for this amendment to be discussed and inserted. Dr. Foster will discuss that at that point and I would suggest that the amendment be withdrawn for this particular resolution and reintroduced when we consider the internal medical fees.

SPEAKER CHARNOCK: Dr. Bullock.

DR. BULLOCK: Mr. Speaker, this is most appropriate here because with this introduction the internists in the room are liable to go along with unity. If we are going to have the increase of the ceiling to this level to include the great majority of our practice of internists in the room I think we are going to vote against it. I certainly am. With this amendment we will vote for it. Therefore, I think it is appropriate to make a decision before we go up to \$6,000. Is a further internal medicine aid going to be included in C.P.S. or not, or if the fact that it is not in be clearly recognized by all concerned at the present time.

DR. TEALL: I would like to make one additional comment that I failed to make. It is perfectly obvious that Dr. Bullock will vote against any attempt of his branch society to request a \$6,000 option within its own level. This is his privilege and it is the privilege of any internist who feels that the \$6,000 ceiling should not be adopted, and I hope that everyone else will look very critically at whether it should be adopted with the provisions available. However, I still feel that this amendment does not belong in this section of the resolution and request that you defeat it at this time.

SPEAKER CHARNOCK: Is there any further discussion to the amendment? Section 4 of this resolution?

A MEMBER: Question.

SPEAKER CHARNOCK: The question has been called for. Those in favor of Dr. Bullock's amendment which will become Section 4 if passed, will signify by saying "aye." To the contrary?

... There being no further discussion, the motion was put to a vote. ...

SPEAKER CHARNOCK: The Chair is again in doubt. Those who are in favor of Dr. Bullock's amendment will please stand.

... There was a standing vote. ...

SPEAKER CHARNOCK: Those opposed to this amendment please stand.

... There was a standing vote. ...

SPEAKER CHARNOCK: It carries by 105 to 82.

We will proceed, please, with this resolution as amended. Doctor?

DR. MOORE (San Diego): I am discussing the resolution.

SPEAKER CHARNOCK: All right.

DR. MOORE: Mr. Speaker, Members: I would like to discuss part 3 of the resolution, No. 5, stating that physician members of C.P.S. in a county which has not requested the higher ceiling, abide by the income ceiling for beneficiaries who have secured this coverage in some other county society area.

Now my understanding is that C.P.S. is primarily engaged in the sale of group policies. The policy is sold to groups, and only a small percentage of individual policies have been issued. Under ordinary circumstances the only way in which this particular condition could occur is when an individual leaves a group where he is employed and moves to another part of the state. In such event he is issued a special contingent contract. His group contract no longer exists. He is issued a special individual contract at a higher rate.

Now I can picture that individual no longer with the group given a special contract, going to another county, coming into my office and demanding that I treat him under a \$6,000 ceiling income where in our particular county we do not do that and I can picture each of those patients doing that and making the doctor mad. I don't think we want to make the doctor mad. So I would like to move that Paragraph 3 of Resolution No. 5 be deleted.

SPEAKER CHARNOCK: You are moving to amend by deletion? Is there a second to that? The Chair has heard no second.

A MEMBER: Second.

SPEAKER CHARNOCK: It has been seconded. Is there any discussion on deleting Section 3? Yes, Dr. Miles.

DR. MILES (Monterey County): I think that the doctor is being a little rash in presuming that a patient would have to leave one area and leave his job in order to move to an area where he would be asking the aid of a physician in another county. I think that it is particularly evident in California that you can live in San Mateo County and work in San Francisco and that your contract would be issued in San Francisco or that you could live in

Berkeley or Oakland and your work be in San Francisco but your physician would be in the other county, so I would ask you to consider again before you pass that amendment because of this.

SPEAKER CHARNOCK: Is there any other discussion to the amendment which is an amendment to delete Section 3?

DR. CAREY (Yuba): We have labored for two years over this on the Medical Services Commission. We have worked hard and long. I counted up the other day that this commission has put in thirty-six days of its time in either travel or consideration of these problems in this Association. In that time we have heard from dozens, almost hundreds of different people in organizations, and we have tried the best we can to come up with solutions which we felt would be to the general advantage of the public and to the medical profession as well. In the matter of this \$6,000 schedule we are speaking about, I wonder if it is entirely clear to the House that C.P.S. is not discontinuing the rate of its \$4,200 financial limit at the present time. This is not a fact at all. What we are doing in this particular resolution is the introduction of an entirely different policy, one that will contact a \$6,000 schedule.

SPEAKER CHARNOCK: Now, Dr. Carey, may I interrupt just a moment. Are you speaking to the amendment?

DR. CAREY: Yes, sir.

SPEAKER CHARNOCK: Right.

DR. CAREY: This is a preamble to the amendment. (Laughter.)

Now, if the county requests that C.P.S. write this sort of thing in their county the rest of us throughout the state are agreed that we will respect their decision in that manner. Now, in regard to No. 3, in order to have a local option, in order to make the \$6,000 schedule that we are talking about here operate at all, we must have that Section 3 in there. That is, those of us that are not involved in that particular county, they must respect the \$6,000 level that the county, that Orange County has accepted if we are to implement this thing and make it effective at all.

This is taken by your Study Committee as an alternative to offer you a \$6,000 state-wide ceiling. We didn't feel that you, nor did we, agree with that but we did feel that there are many areas in California where the fires are burning hot and where men are making various and sundry attempts to solve their individual problems, not only with plan systems but with other systems as well. And it is to offer these men a tool to work with that we have set up this particular plan. I hope you will turn down the amendment as proposed.

SPEAKER CHARNOCK: Thank you, Dr. Carey. I wanted to be sure you were talking about this amendment. Is there any other discussion?

DR. DAVIS: I should like to ask a question. I am a little bit confused as to the matter of procedure. Does this mean that the contract is issued in the county in which the major number of employees

happen to reside or happen to work, or does this mean that the contracts on a state-wide basis will still have a certain amount of local control but that if a patient who is in one spot and moves to another spot is still covered?

In other words, put it this way, Standard Oil Company has one large group with C.P.S. I don't know where the largest group of Standard Oil employees happens to reside. I presume it is in Los Angeles. I don't know either just where the main office of Standard Oil is. I think it is in San Francisco, but it may also be in Los Angeles. In any event, is this to be interpreted that a contract then which is issued and gives certain rights, privileges and prerogatives to employees of the Standard Oil Company, and is issued in Los Angeles under the auspices and approval of the Los Angeles County Medical Society becomes applicable to all Standard Oil employees who may be in any other part of the state, in portions of the state where only a few of the employees are at present located?

Because if that be true then the more large groups that we take into the C.P.S., the more of these that we get, the larger percentage of the total people covered who belong to those large groups, the more effective then the larger counties will be in deciding whether or what the conditions will be under which the less populous areas will practice. I would like that cleared up.

SPEAKER CHARNOCK: Thank you, Doctor. Are you going to answer that?

DR. TEALL: Yes, sir.

DR. TEALL: Mr. Chairman, the position as outlined by Dr. Davis is the way we see the situation. It is impossible in any resolution before this House to spell out every contingency of every small point and policy, but I believe that your statement of what would happen in a Standard Oil group is what is anticipated by Section 3 here. A phrase was coined in consideration of this matter which I think is an excellent phrase, that the adoption of this section of this resolution is a manifestation of the *esprit de corps* of all of the doctors in California who are physician members of California Physicians' Service in helping local branches or local county societies to solve their own problems. (Applause.)

SPEAKER CHARNOCK: Is there any further discussion on the amendment?

A MEMBER: Question.

SPEAKER CHARNOCK: Those who are in favor of the amendment made by Dr. Moore to delete Section 3 will signify by saying "aye." Those who are opposed to the amendment to delete Section 3 will signify by the usual sign.

... There being no further discussion, the motion was put to a vote. . .

SPEAKER CHARNOCK: Now, the Chair is confused. The amendment has lost. The Chair is back on the beam. Excuse me, gentlemen. Will you proceed with moving the adoption?

DR. FOSTER: I move the acceptance of this section of the report as amended.

SPEAKER CHARNOCK: It has been moved and seconded that this section of the report be adopted as amended. Is there any discussion? Dr. Bender. (Laughter.)

DR. BENDER: Mr. Speaker, and members of the House: My remarks will be very brief. I think what a number of us are worrying about is the fact that something just the reverse of what Dr. Davis has suggested might take place. For instance, in San Pedro the Longshoremen's Union might be signed up to a contract on the San Pedro schedule under a \$4,200 ceiling which is under the current fee schedule without a ceiling. That then would become state-wide and the local—or the whole state would be stuck with it.

That is what people are concerned about and that is what would destroy local option in the true sense of the word.

The other remark I have to make is that is unless the acoustics were wrong where we happened to be sitting back there the author of Resolution No. 5 has stated that he didn't see any reason for it at all, and I urge that as a reason for voting against it. (Laughter.)

SPEAKER CHARNOCK: Is there any further discussion to the acceptance of this section of the report? Dr. Sirbu of San Francisco.

DR. SIRBU: Mr. Speaker, I will be very brief.

Just two points. In the first place by defeating the amendment of making the Usual-Fee Indemnity Plan on the local basis you have spoken against that particular issue piecemeal.

Now it is the contention of many of us, substantiated by the word of many of the members of the Medical Services Commission, that Resolution No. 5 as amended is not the ideal answer. Primarily the Usual-Fee Indemnity Plan is the answer of organized free medicine to this problem. It is also the expressed opinion of members of the Medical Services Commission that the adoption of Resolution No. 5 will delay and impair the eventual formulation of the Usual-Fee Indemnity Plan which is the ideal plan.

Now, by voting for Resolution No. 5 you are in effect defeating the best plan that is possible. Certainly you are delaying it for a long period of time.

Now, gentlemen, there is just one question I think that we should have answered here. We are asked to raise the ceiling to \$6,000 which is in effect a 42 per cent increase in the ceiling which incorporates some 25 or 30 per cent more of the people under this service plan. I think that before we take that action we should be entitled to know, not exactly but in generalities at least, approximately what fee schedule we will be operating under. I submit that if you want unity, not only between the internists and the rest of the profession, but between all of organized medicine, be it specialists, be it urban practitioners or be it country practitioners, we should know approximately what's going to happen on this.

I again submit that when we adopt this it is going to influence our negotiations with every prepaid medical plan. We have been given to understand that

the most likely initial fee will be about 10 per cent higher than the present scale. We have also been given to understand that that might be weighted more on the visits basis rather than on the Southern California medical procedures basis.

I think we are entitled to know what we are voting about. I would like to ask that question. (Applause.)

SPEAKER CHARNOCK: All right, Dr. Foster.

DR. FOSTER: I wish I could answer that question clearly but on equivocation I cannot do it. The reason I cannot do it is that the recommendations of the Fee Schedule Committee have only been formulated within the past few hours and they are not in sufficiently final shape that we feel they should be reported here, because it may be necessary to make additional revisions. I think the statement made by Dr. Sirbu is approximately correct, that possible changes are in the neighborhood of 10 per cent in fees and 10 per cent in premiums but that is a point again that cannot be stated as an accomplished fact or an absolute recommendation at this point.

I would like to emphasize what I said a moment ago, however, which I think should clarify this, we are not asking San Francisco to adopt a \$6,000 ceiling. We are not asking Los Angeles to adopt a \$6,000 ceiling. We are not asking any society or any branch or any doctor to support or adopt a \$6,000 ceiling. If in your situation you feel that a \$6,000 service contract is desirable, you have the privilege of requesting that C.P.S. write that contract in your area.

You already have that privilege as a matter of actual operational procedure. At the time that you request it there is every reason to believe that C.P.S. will be able to tell you to the nearest decimal point what the proposed fee schedule will be on a statewide basis for those \$6,000 contracts. I wish I could answer it. I cannot. But you will answer it for yourself before you request on the basis of your own decision, on the basis of your own need, as to whether you do or do not want the \$6,000, and you will have every opportunity to accept or reject the proposed fee schedule at that time. (Applause.)

SPEAKER CHARNOCK: You have heard the discussion upon the acceptance of this resolution.

DR. ROLF (Westwood Village): I personally believe there is no universal solution to this problem. That we are too heterogeneous a population in this state. I have practiced in both rural and urban areas and I can appreciate the difficulties the committee has gone through in trying to arrive at this solution.

I know also that rural people or small community people will go to specialists in the large city and as this resolution is written I think it is dangerous in that way, especially as the facts the medical man whom these people will come to see for diagnosis where they expect an hour of time rather than the five- or ten-minute office call. A service type contract at present could permit a doctor to conduct a dispensary type of service seeing perhaps ten patients an hour if he would care to assign that time to specific patients. In Part I, I believe that you are signing a blank check unless there is some specific notation

as to what type of income comes with a \$6,000 ceiling. Actually I believe this would take about 90 per cent of each doctor's practice. Personally I believe this resolution should be tabled until we have had more specific matters discussed. Thank you.

SPEAKER CHARNOCK: Dr. Mauer.

DR. MAUER: Mr. Chairman, members of the House of Delegates: A \$4,200 income ceiling was selected to provide medical service for a low income group. The \$6,000 income ceiling is designed for an entirely different problem. I merely wish to point out that should it be adopted the pattern of the fee schedule under the contracts written at that level will serve as a pattern for all other insurance carriers, private as well as public.

SPEAKER CHARNOCK: Thank you, Dr. Mauer.

DR. MILLER: Mr. Speaker, was there not a motion to table this resolution?

SPEAKER CHARNOCK: I heard none.

DR. BLOCH (San Pedro): It seems that the southern branches of Los Angeles County, San Pedro, has been the offending party in this deal inasmuch as the doctors in San Pedro were faced with the condition which demanded revision of the C.P.S. ceiling. With your permission I would like to have the doctor, Dr. Korn, who has been the chairman of this committee of doctors in the southern branch, go into the details of this conversion.

A MEMBER: No.

SPEAKER CHARNOCK: Dr. Korn is not a member of this delegation. It will require unanimous consent. Do you wish to put that to the House?

DR. BLOCH: If you will, please.

SPEAKER CHARNOCK: Dr. Korn from San Pedro has information regarding this matter. It will require unanimous consent of the House for him to appear before you. All those who are in favor of Dr. Korn's appearing will signify by saying "aye." To the contrary?

... There being no further discussion, the question was put to a vote and it was lost. ...

SPEAKER CHARNOCK: Dr. Korn is out. Is there any more discussion? Dr. Green.

PRESIDENT GREEN: Mr. Speaker, members of the House: I should like to say a word to this question. This reminds me of a large family who wish above all else to build a wonderful building, an edifice that they will be proud of and will be succeedingly proud of in other generations. So they select after a discussion an architect in whom they believe thoroughly. They have discussed the number of architects that they might have. So your architect has been selected. Then the architect in the very beginning says, "All of you being members of the family, what would you like to have?" And after several weeks and many hours of deliberation and one thing and another you think you have all the specifications. You have everything that you desire.

After that is all done then the architect comes in and he has made a drawing of what he believes that

you should like to have. And you tell your architect, "I don't want to look at the picture."

SPEAKER CHARNOCK: Thank you, Dr. Green. I am sure the Los Angeles delegation is fully familiar with architects. (Laughter.)

Dr. Carey.

DR. CAREY: As one of the architects I would like to pass on another bit of information to you. Oregon and Washington to your north both have \$6,000 ceilings. There are several other states that have \$5,000 ceilings. I thought you would be interested in knowing that.

SPEAKER CHARNOCK: Is there any further discussion upon this resolution as a whole? The Chair hearing none—Those who are in favor of the passage of Resolution No. 5 as amended will signify by saying "aye." To the contrary?

... There being no further discussion, the motion was put to a vote. ...

SPEAKER CHARNOCK: The Chair is in doubt. Will those who are in favor of passing this resolution as amended please stand? Will all those in the wings come in so they may be counted because this is an important vote.

DR. TRUMAN: Mr. Chairman, there is a doubt as to the amendment. Would you please have it read before the vote is taken?

SPEAKER CHARNOCK: It was Dr. Bullock's amendment making a passage of No. 4 as the amendment, sir. It makes a Section No. 4, let's put it that way, I didn't mean to pass it.

DR. TRUMAN: Wait a minute. May we please sit down and have it read?

SPEAKER CHARNOCK: All right. That will be read again. Will you please sit down? Mr. Secretary, will you read the amendment which has been passed? Will Dr. Bullock please read it? This is the amendment which has been passed and which forms Section 4 of this report.

DR. BULLOCK:

"Resolved—"

One, two and three are exactly as they are at the moment and in addition thereto Paragraph or Section 4 reads as follows:

"WHEREAS, The present fee schedule does not adequately cover the type of service characteristic of the practice of internal medicine that beneficiaries of C.P.S. either be advised that the services of internists are not included or that the directors of C.P.S. be instructed to immediately develop a method for covering services of internists for beneficiaries of C.P.S."

SPEAKER CHARNOCK: Is that quite understandable now?

DR. TRUMAN: Thank you.

SPEAKER CHARNOCK: Will the members in the back of the room or the spectators if they so be, who are not voting on this proposition or are not entitled to vote, will you please sit down? Squat down, I guess it will have to be.

Now, those who are in favor of Resolution No. 5 as amended will please stand.

... There was a standing vote. ...

SPEAKER CHARNOCK: Will you please be seated, gentlemen? Those who are opposed to Resolution No. 5 as amended please stand.

... There was a standing vote. ...

SPEAKER CHARNOCK: The resolution wins 128 to 81. Thank you, gentlemen. At this time I would like to have you take a deep breath in order for the stenographer to change her little reel and get ready for another two or three hours.

At this time I would like to present John Marshall and Gene Mendelsohn. Will Jerry Pettis please bring them forward?

John Marshall is a Junior in the College of Medical Evangelists and is president of the Student A.M.A. section. John Marshall. (Applause.)

Gene Mendelsohn is a sophomore at U.S.C. and is president of the Student A.M.A. at that institution. These young gentlemen were pulled out of their work at their respective schools to come to be presented to the House today. Thank you for being here. (Applause.)

These young gentlemen recently appeared in Chicago at the Student A.M.A. Convention.

Dr. Foster, will you proceed?

DR. FOSTER: The next resolution, Number 9, introduced by Samuel Sherman, San Francisco County. It was originally referred to Reference Committee No. 3. Finally it got over to us and in between the two of us, between the two committees it didn't get printed so I will read it to you.

"WHEREAS, The C.P.S. has now established two different methods for prepayment care of the sick, namely service type plan and indemnification plan; and

"WHEREAS, These two types differ in structure, organization, required reserve and are under different jurisdiction, namely, one, the service type under the Attorney General, two, the indemnity type under the Insurance Commissioner; and

"WHEREAS, Under the above conditions the financial structure must of necessity be separate and distinct; therefore, be it

"Resolved, That the financial contribution of the service plan to the indemnity plan be limited to the very minimum necessary to assure performance of contracts entered into; and

"Second, that the directors of the Indemnity Corporation conduct its business in a conservative manner."

Resolution No. 9 in effect calls for minimizing the activities of the Indemnity Corporation previously authorized by the House of Delegates. This resolution is incompatible with vigorous prosecution of the Usual-Fee Indemnity Plan as recommended by the Medical Services Commission and previously authorized by the House of Delegates.

Therefore, your committee recommends it "Do Not Pass."

SPEAKER CHARNOCK: It has been moved and seconded that Resolution No. 9 do not pass. Is there any discussion? Dr. Sherman.

DR. SHERMAN: Mr. Speaker, I cannot reconcile my thinking with that of this Reference Committee. It was not the intent of the Resolutions Committee which formulated this resolution to in any way at all minimize the activities of the Indemnity Plan. We are very hopeful that when the Medical Services Commission is able to implement the Usual-Fee Indemnity Plan and put these plans in operation that they will go into operation but on a sound, conservative, businesslike basis. It will be one which will not tend in any way at all to bankrupt the financial facilities of our service plan which is in effect subsidizing this Indemnity Plan.

To quote the words of Mr. Hamman, the Director of C.P.S., when this was discussed in the Reference Committee, he said that "Dr. Sherman in his resolution sounds very much like the Directors of C.P.S. when they urge conservatism and caution in entering into these indemnity plans." That was our only intent and we hope that you people will recognize it as such and support the passage of this resolution.

SPEAKER CHARNOCK: Are you discussing this resolution?

DR. OGDEN (Kern County): Yes, I was somewhat hopeful that this resolution would hinder the expansion of the Indemnity Plan in C.P.S. The time has passed when we as doctors are going to say what we want, what we are going to receive in the way of pay and what we are going to do to a great extent. The plans we sell are going to be the ones we can sell, possibly not the ones we want, but the ones we can sell and in spite of the formidable evidence and of the testimony of men that I readily admit are much smarter and of much greater experience than I am, that Indemnity Plan isn't what people want or the one that can work better. I am completely unconvinced that an Indemnity Plan is the one they want. From the experience that we have had for thirty years in Kern County we have had a full service plan, a plan with no limitation, no qualifications at all, a complete, full service plan with no income ceiling.

In 1926 the Supervisors of Kern County built a 600-bed County Hospital, a beautiful hospital, beautifully equipped with a full staff which they paid. In order to justify that and to show that the Supervisors were for the taxpayers, there was a wide-open admission policy. As it came out in one of the official publications from the County Hospital, the use of the County Hospital shall be as free to the taxpayers as use of the roads.

Our people liked that plan. They liked it so much in fact that about the only way we ever get rid of a Supervisor is to have him die off. A Supervisor told a committee of the Medical Society when we checked on him one time, we met with him once and he told us that he was not in favor of a wide-open hospital policy. He came out in the paper in an advertisement that he was in favor of it. When we got hold of him he said, "I am not really in favor of it but

nobody can get elected in Kern County who is against a wide-open hospital policy."

What people want, at least in Kern County, is a service plan as wide and as free as they can have it. So I was hopeful that this resolution was to some extent going to hinder the service policy. Thank you, gentlemen.

SPEAKER CHARNOCK: Is there any other discussion to this resolution?

SPEAKER CHARNOCK: Are you ready for the question?

DR. FOSTER: When Dr. Sherman discussed this resolution he said that he felt that the Board of Trustees were conservative as I understood his reactions, and it seemed to the Reference Committee that this resolution was a matter of more or less of a vote of confidence, and I believe that a vote of confidence could be best given to our Council and Medical Services Commission by voting "Do Not Pass."

SPEAKER CHARNOCK: Are you ready for the question?

A MEMBER: Question.

SPEAKER CHARNOCK: You will realize that in voting "yes" on this resolution you will kill the resolution. Voting "no" upon the resolution, then the resolution will stay as read. Those who are in favor of this section of the report will signify by saying "aye." To the contrary?

... There being no further discussion, the motion was put to a vote and it was carried. ...

SPEAKER CHARNOCK: This section of the report is passed. Will you proceed?

DR. FOSTER: Resolution No. 10, introduced by Dr. Samuel R. Sherman of San Francisco County.

"That the C.P.S. Trustees carry only the average reserve recommended by the National Association of Insurance Commissioners in order that the full amount of an adequate Fee Schedule can be paid."

This is an administrative function, and should be left to our responsible elected representatives.

Action taken by this House at the Interim Session in December 1953 equalized the value of units to avoid month-to-month variations, so that the Unit Stabilization Fund is not expected to increase at an unwarranted rate.

Your committee therefore recommends "Do Not Pass."

Mr. Speaker, I move the adoption of this section of the report.

SPEAKER CHARNOCK: This section of the report has been moved and seconded. Is there any discussion?

A MEMBER: Question.

SPEAKER CHARNOCK: You will realize again that voting for this section of the report kills the resolution. Those in favor of this section of the report will signify by saying "aye." To the contrary?

... There being no discussion, the motion was put to a vote and it was carried. ...

SPEAKER CHARNOCK: This section of the report is passed.

DR. FOSTER: Resolution No. 11, introduced by Samuel R. Sherman, San Francisco County Medical Society. I believe that you have this in front of you but I will read just the reaction of the committee. The complexities of fee schedule determination are beyond the capacities of a half hour's debate in this House and this problem must be referred for immediate implementation, recommendation and action to the Medical Services Commission. Therefore, we refer this resolution to the Medical Services Commission.

Mr. Speaker, I move you the adoption of this section of the report.

SPEAKER CHARNOCK: In adopting this section of the report this resolution is referred to the Medical Services Commission. Is there any discussion?

A MEMBER: Question.

SPEAKER CHARNOCK: Those who are in favor of this section of the report will signify by saying "aye." To the contrary?

... There being no further discussion, the motion was put to a vote and it was unanimously carried. ...

SPEAKER CHARNOCK: You may proceed.

DR. FOSTER: Resolution No. 12, introduced by Samuel R. Sherman, San Francisco County Medical Society.

"Resolved, That if the \$6,000 gross family annual income ceiling is adopted by the C.M.A. House of Delegates with its accompanying increased fee schedule, C.P.S. may be permitted to write policies for lower income ceilings provided that there be concomitant and equitable increases in the C.P.S. fee schedule for these groups."

The committee reemphasizes the fact that the adoption of the \$6,000 ceiling is on a local option basis. The creation of several levels of family income ceilings would become confusing and impractical, and for this reason your committee feels it would be an unwise procedure.

We therefore recommend this resolution "Do Not Pass." Mr. Speaker, I move the adoption of this section of the report.

SPEAKER CHARNOCK: This section of the report has been moved and seconded and is now open for discussion.

A MEMBER: Question.

SPEAKER CHARNOCK: Those who are in favor of this section of the report—I again emphasize this is a "Do Not Pass"—will signify by saying "aye." To the contrary?

... There being no discussion, the motion was put to a vote and it was carried. ...

SPEAKER CHARNOCK: This section of the report is passed.

DR. FOSTER: Resolution No. 13, introduced by Garnett Cheney, for the California Society of Internal Medicine.

"Resolved, That the following principles be accepted:

"1. Each physician member rendering service as a C.P.S. professional member shall be requested to declare himself as to his field of practice, whether surgical or non-surgical.

"2. A non-surgeon member shall be a physician who derives 5 per cent or less of his professional income from surgical procedures.

"3. The present fee schedule of C.P.S. is to be elaborated to include a detailed schedule of diagnosis and treatment of major medical illnesses.

"4. Physicians practicing as non-surgeons shall be prepared to make available upon request a suitable case report to the Medical Director of C.P.S."

The intent of this resolution has been anticipated by current activities of the Medical Services Commission and its Fee Schedule Subcommittee. There will be inaugurated immediately a pilot program to determine whether or not the total fee concept is applicable to major medical illnesses. The Medical Services Commission has assured the Reference Committee that it will press for an early solution.

In view of the above conditions, the committee recommends "Do Not Pass."

Mr. Speaker, I move the adoption of this portion of the report.

SPEAKER CHARNOCK: This portion of the report has been moved and seconded. Is there any discussion?

A MEMBER: Question.

SPEAKER CHARNOCK: I again emphasize this is a "Do Not Pass." Those in favor of this section of the report will signify by saying "aye." To the contrary?

... There being no further discussion, the motion was put to a vote and it was carried. ...

SPEAKER CHARNOCK: This section of the report is adopted.

DR. FOSTER: Resolution No. 15, introduced by Randolph G. Flood, San Francisco County Medical Society.

"Resolved, That if the \$6,000 gross family annual income ceiling is adopted by the C.M.A. House of Delegates with its accompanying increased fee schedule, that this income ceiling level and its fee schedule be considered the only ones in existence on the expiration of all present C.P.S. policies."

It is important to medicine that it retain the program for the low income group, an important intent of C.P.S. It would be unjust to compel people with low incomes to pay the higher premium required for higher income groups. Furthermore, this would substitute the \$6,000 income ceiling state-wide, rather than on a local option basis, which is contrary to our previous recommendation.

Therefore, the committee recommends "Do Not Pass."

Mr. Speaker, I move the adoption of this section of the report.

SPEAKER CHARNOCK: This section of the report has been moved and seconded. Is there any discussion?

A MEMBER: Question.

SPEAKER CHARNOCK: Again a "Do Not Pass." Those in favor of adopting this section of the report will signify by saying "aye." To the contrary?

... There being no further discussion, the motion was put to a vote and it was unanimously carried. ...

SPEAKER CHARNOCK: It is passed. Proceed, Dr. Foster.

DR. FOSTER: Resolution No. 17, introduced by Dr. Edward H. Crane, Jr., of the Inglewood Branch of the Los Angeles County Medical Association.

"Resolved, That the House of Delegates instruct the Directors of C.P.S. to set up a fee schedule which is 75 per cent higher than the original 1939 fee schedule. Be it further

"Resolved, That the Directors of C.P.S. be instructed that they may pay that per cent of this fee schedule that is consistent with a solvent operation. Be it further

"Resolved, That the Directors of C.P.S. review this schedule each year for question of alteration."

The committee rejects the resolution contemplating an increase of 75 per cent in the 1939 medical fees.

The Medical Services Commission is now making a relative value fee survey, from which it is hoped a realistic fee schedule will be established. There is no purpose in compounding the inequities of an old 1939 schedule on any basis.

For these reasons, your committee recommends "Do Not Pass."

Mr. Speaker, I move the adoption of this portion of the report.

SPEAKER CHARNOCK: It has been moved and seconded that this section of the report be adopted. Is there any discussion? Dr. Crane.

DR. CRANE: I had hoped that the committee would read all the whereases in this resolution. It seems to me that their conclusions here have more or less disregarded the purpose of the resolution. We have set here in this meeting today a possible ceiling for any portion of the state of \$6,000 for C.P.S. I see no reason why a C.P.S. fee schedule should not reflect the usual fee that you and I charge for what we do. The purpose of this resolution wasn't designed to immediately increase the amount of money that is paid the physician. That wasn't the desire of the resolution at all, and if you read the whereases you will see that this is true.

Our purpose was to set up in our C.P.S. fee schedule a schedule which reflects the thinking of the medical profession in this state as to what their services are worth as a means of a yardstick for insurance companies and other companies to be guided by so they will know what we feel in our own business, what our services are worth.

In this resolution it is stated that we would so instruct the Directors of C.P.S. to pay whatever portion of that fee schedule was commensurate with a solvent operation. In other words, we aren't asking that they increase the amount of money paid to the doctor at this time at all. That isn't the purpose of this resolution at all. So how can it possibly be com-

pounding an inequity? It couldn't possibly be compounding an inequity. If there are some small inequities in the original fee schedule, certainly there will be inequities in the increased fee schedule.

But what we are after here, and I want to reiterate this, what we are after here is to have on paper what we feel as medical men is an adequate fee for our services. If C.P.S. hasn't progressed to the point where they can pay that much yet, well that is fine. We will go along with that 100 per cent, but we feel that the public should know what we feel our services are worth and that is the purpose of this resolution, and I feel that the committee has entirely ignored that. (Applause.)

DR. KILROY (Sacramento): In considering this resolution the committee of course must consider the body of the resolution in the resolve and in that body it is stated that there would be a 75 per cent increase based upon the 1939 fee schedule. The inequities arise in the 1939 schedule and arise on this basis, a fact probably not known by too many, but that schedule was derived in actuality from the industrial accident fee schedule then in force. That was a traumatic schedule and certainly one that was unfair to those performing medical services.

It has been stated earlier and a statement with which I am in complete agreement, that those doing medical practices have not received a fair consideration. And certainly the 1939 schedule gave them practically no consideration. Considering therefore that there were inequities to raise that by 75 per cent is only compounding a felony. (Applause.) Therefore, your committee in considering the very basis for which this 1939 schedule arose felt that it could not be guilty of such compounding of a felony. Thank you.

SPEAKER CHARNOCK: Is there any further discussion on this section of the report?

DR. TEALL: Mr. Chairman.

SPEAKER CHARNOCK: Dr. Teall.

DR. TEALL: There are two problems involved in this resolution which I think it important to point out. First, that the House of Delegates instruct the Directors of the C.P.S. to set up a fee schedule. It has been the established practice that the fee schedule in so far as it concerns the relative value of the items, that that fee schedule arise from the California Medical Association as such and not from the California Physicians' Service administration. The function of the California Physicians' Service administration is to determine what may be paid on the basis of money in the pot at that moment on that fee schedule. It therefore will be narrower to pass this resolution as it stands directing the C.P.S. Trustees to set up a fee schedule.

The second problem is that the 1939 fee schedule was not set up in dollar units. You will remember that the original principle which was still in operation was that we would set up fees in relative values, that is, in units rather than dollars, and we just got in the bad habit of thinking of those units in terms of a pertinent part, but if we were to take the 1939

fee schedule and increase it by 75 per cent it would still be no schedule that was evaluated in dollars, so it would mean nothing for the purpose for which this resolution was introduced. If we were to take the 75 per cent increase of the 1939 fee schedule and put a dollar per unit value on it we might get somewhere, but remember that there have been several revisions of that fee schedule made since 1939 in an attempt to straighten out the inequities to which Dr. Kilroy just addressed himself.

We would therefore by going clear back to 1939 be compounding a much worse felony than if we were to simply add a certain flat percentage to the fee schedule as it exists today. It seems to me that this is a problem, just as pointed out by the Reference Committee, which is extremely difficult of solution that it is impossible to set up at this moment by any arbitrary fee schedule which is in existence a fee which all of us could accept as being a reasonable value of our own personal services wherever we practice within the state. I don't know whether it would be in order to simply propose that to defeat this, do not pass it as the Reference Committee has suggested, or whether you wish to refer it to the Council or to the Medical Services Commission for further study as reported there.

A MEMBER: Question.

SPEAKER CHARNOCK: The question has been called for. Those who are in favor of passing this section of the report will signify by saying "aye." To the contrary?

... There being no further discussion, the motion was put to a vote and it was unanimously carried. . . .

SPEAKER CHARNOCK: This section of the report is passed.

DR. FOSTER: Resolution No. 24, introduced by Carl M. Hadley of San Bernardino, San Bernardino County.

SPEAKER CHARNOCK: Dr. Foster, will you go back to Resolution No. 19?

DR. FOSTER: I am getting in a hurry.

Resolution No. 19, introduced by Henry Gibbons III, San Francisco County.

"Resolved, That the House of Delegates request the officers of C.P.S. to study and recommend means for the inclusion of specialized services in the benefits of its insurance policies."

This resolution describes a function which is not properly within the province of the officers of California Physicians' Service.

For this reason, the committee recommends "Do Not Pass."

Mr. Speaker, I move the adoption of this section of the report.

SPEAKER CHARNOCK: This section of the report has been moved and seconded. Dr. Gibbons.

DR. GIBBONS: I do not quite understand or agree that this is not the province of the C.P.S. office to study but for the purposes of discussion I would like to move to amend this report by reintroducing this resolution for consideration.

SPEAKER CHARNOCK: I did not get that, Dr. Gibbons.

DR. GIBBONS: I would like to move to amend this report by reintroducing the original resolution for discussion.

SPEAKER CHARNOCK: Is there a second?

A MEMBER: Second.

SPEAKER CHARNOCK: It has been moved and seconded that the original resolution be introduced. Will you read the original resolution?

DR. FOSTER:

"WHEREAS, The maintenance of good health care is a prime function of the medical profession, and is essential for the success of voluntary sickness service plans; and

"WHEREAS, Adequate availability of service by medical and surgical specialists is an integral part of good health care; now, therefore, be it

"Resolved, That this House of Delegates request the officers of C.P.S. to study and recommend means for the inclusion of specialist services in the benefits of its insurance policies."

SPEAKER CHARNOCK: Now, this is the original resolution as introduced by Dr. Gibbons, and does not constitute an amendment. Are you now going to discuss this, Dr. Gibbons?

DR. GIBBONS: May I discuss the resolution?

SPEAKER CHARNOCK: The resolution as just read?

DR. GIBBONS: The discussion of the resolution then, it might be pertinent to ask for an opinion where this belongs. Regarding the resolution it may not be of immediate importance if this resolution is passed, but it must be admitted that the members of the medical profession practice side by side in communities where medical and surgical specialties are recognized both by doctors and by patients. And to defeat this resolution only serves to deny the truth of this situation.

Furthermore, making a study of including specialists' services in insurance policies, I believe, is long overdue. Therefore it would seem to me a healthy and forward-looking move to request C.P.S. officers to make such a study which is all this resolution calls for, and I urge the passage of this resolution.

SPEAKER CHARNOCK: Dr. Gibbons, may I alter that and say that you urge that you are speaking for the resolution as originally introduced? Now the only thing that Reference Committee did was to just take the resolve, it is exactly the same. So if this is not passed, why then your resolution stands as—

DR. GIBBONS: Yes.

SPEAKER CHARNOCK: Do I make myself clear?

A MEMBER: No.

DR. GIBBONS: If my resolution passes then that original resolution calls for referring to the C.P.S. officers to study.

Now, maybe somebody would like to question the opinion on that score.

SPEAKER CHARNOCK: As the Chair sees the proposition Dr. Gibbons has put in, he originally amended

the report of the Reference Committee by reintroducing exactly the same resolution that the Reference Committee has reported on, the resolve which the Reference Committee is reporting on is identical with the resolve in Dr. Henry Gibbons' resolution as I have it before me here, so he is just speaking against the passage of this section of the report.

Dr. Hodges.

DR. HODGES: May I state for the Board of Trustees of the California Physicians' Service that it would mean if Dr. Gibbons' resolution passed that the California Physicians' Service would then be put into the position of deciding who is and who is not a specialist. In effect it would become a pseudo certifying board and I don't think it is fair to put your California Physicians' Service in that position. (Applause.)

SPEAKER CHARNOCK: Dr. Askey. We will get expert clarification. (Laughter.)

DR. ASKEY: Ladies and gentlemen: In my capacity as past president I have a voice but no vote, so I just had to have one appearance before you. This is a very interesting thing to me in parliamentary procedure. Dr. Gibbons' resolution is before you. He doesn't have to reintroduce it at all. The only thing is that this committee is recommending that you don't pass it.

Now, if you don't want to pass it you vote for the committee. If you want Dr. Gibbons' resolution, kill this motion and it is passed. However, to clarify the thing, and using my voice, I would move that this be committed to the Medical Services Commission for further study.

A MEMBER: Second.

SPEAKER CHARNOCK: Are you moving to refer?

DR. ASKEY: Yes, sir.

SPEAKER CHARNOCK: Is there a second?

A MEMBER: Second.

SPEAKER CHARNOCK: It has been moved and seconded that this section of the report be amended to refer this to the Medical Services Commission. Any discussion? Those in favor of voting to refer this resolution to Medical Services Commission will signify by saying "aye." To the contrary?

... There being no further discussion, the motion was put to a vote and it was carried. ...

SPEAKER CHARNOCK: It is referred.

DR. FOSTER: Resolution No. 24, introduced by Carl M. Hadley of San Bernardino County.

"Resolved, That the present system of affording medical and surgical care by California Physicians' Service shall be abolished and a new concept of such care be established in the form of a \$50 annual deductible type of insurance in which the individual family shall pay the first \$50 per year for any medical and surgical expense, and the California Physicians' Service shall pay for the remainder to the limit of five years' care or \$5,000."

The concept of deductible insurance is not a new one to California Physicians' Service nor to the

Medical Services Commission, nor is it one which has been abandoned as one of many programs which can be integrated with others during the course of study.

The resolution as stated will abolish California Physicians' Service in its administration of a service plan, and will abolish the contemplated indemnity plan, establishing in lieu thereof a deductible plan without benefit of prior experience. Feeling this to be unwise, your Reference Committee advises instead that the principle of establishing a third form of insurance plan, a deductible type, be referred to the Medical Services Commission for their consideration and later report.

A long study has already revealed that the principles applying to health insurance with respect to automobile insurance are not necessarily comparable, and that many commercial carriers have entered and already left this field.

We refer this resolution to the Medical Services Commission.

Mr. Speaker, I move the adoption of this section of the report.

SPEAKER CHARNOCK: This section of the report has been moved and seconded to refer Resolution No. 24 to the Medical Services Commission. Is there any discussion?

A MEMBER: Question.

SPEAKER CHARNOCK: Those who are in favor of referring Resolution No. 24 to the Medical Services Commission will signify by saying "aye." To the contrary?

... There being no discussion, the motion was put to a vote and it was unanimously carried. ...

SPEAKER CHARNOCK: It is so referred.

DR. FOSTER: The committee wishes to thank the several hundred enthusiastic delegates who attended the all-day hearing, and appreciate their interest and advice.

The chairman wishes to thank the members of his committee for their 100 per cent support and their long hours of toil.

Dan O. Kilroy, Fred A. Olson, Thomas A. LeValley, Dorothy M. Allen, James E. Feldmayer and especially Shirley Harcourt, our secretary, who stayed up practically all of last night, and on business too (laughter)—at least that is what she said. Our Legal Counsel—we want to thank our Legal Counsel who has spent a great deal of time with us, Howard Hassard, Mr. Roy Hamman of C.P.S., Mr. Rollen Waterson who is very valuable, and Ed Clancy of the California Medical Association Public Relations Department. Their advice and their time are made up and are reflected in here.

Mr. Speaker, I move the adoption of the report as a whole.

SPEAKER CHARNOCK: It has been moved and seconded that we receive this report as amended as a whole.

DR. FOSTER: As amended.

SPEAKER CHARNOCK: Is there any discussion to that? Those who are in favor will please signify by saying "aye." To the contrary?

... There being no discussion, the motion was put to a vote and it was unanimously carried. ...

SPEAKER CHARNOCK: It is passed.

We want to thank those two committees. At this time we will take a few minutes' respite and please be here in exactly five minutes.

... Short recess. ...

SPEAKER CHARNOCK: Will the House please be in order?

SPEAKER CHARNOCK: To conserve time we will have the report of Reference Committee No. 2. Dr. Vaughan.

REPORT OF REFERENCE COMMITTEE No. 2

DR. J. E. VAUGHAN: Chairman, Mr. Speaker, members of the House: Reference Committee No. 2 is composed of Dr. Thomas Hill, Mendocino County, Henry Gibbons III, San Francisco County, and myself.

The committee has reviewed and examined the report of the Secretary-Treasurer and Executive Secretary. We note with satisfaction the actual work of Dr. Albert Daniels as a participant in the field of the Committee on Postgraduate Activities as well as the further efficient work as a member of the Cancer Commission.

The committee wishes to call your attention to the report of the Executive Secretary, Mr. John Hunton, which enumerates his activities.

Mr. Speaker, I move the adoption of this portion of the report.

... The Chair was assumed by Vice-Speaker Bailey. ...

VICE-SPEAKER BAILEY: This portion of the report has been moved and seconded it be adopted. All those in favor say "aye." Opposed?

... There being no discussion, the motion was put to a vote and it was unanimously carried. ...

VICE-SPEAKER BAILEY: This portion of the report is adopted.

DR. VAUGHAN: The budget proposed by the Council was studied and discussed. Due to the action of this House at the first meeting of this session, Item 17B concerning A.M.A. Delegates, it was necessary to make an increase of \$9,000 in the budget, making a total of \$21,000 to cover the anticipated increase in expenses.

Your Reference Committee in studying Item 19, Organization Expense, wished to call to the attention of the House the fact that this item is subject to a monthly budget report to be presented to the Executive Committee for its approval. The committee considered this a very important item for the expenditure of this fund. In view of the large appropriations in the budget the committee wishes to recommend that a careful review of the whole public relations program, both of the California Medical Association and the California Physicians' Service

be made with special attention to the possible duplication of activities and to the expense of the operation. The adoption of this budget will set the dues at \$40 for 1955.

Mr. Speaker, I move the adoption of this portion of the report.

VICE-SPEAKER BAILEY: It has been moved and seconded this portion of the report be adopted.

Dr. Lum.

DR. LUM: Mr. Chairman, I would like to announce that the Committee on—Wait a minute, I will get that.

VICE-SPEAKER BAILEY: We have quite an assortment here.

DR. LUM: After so many hours your brain cells get a little fatigued.

That the Committee on Public Relations make a very careful study and evaluation of public relations and C.M.A. in order that there will be no duplication and in order that public relations will be carried out most effectively.

I would like to name the personnel of that committee, read it for you. Chairman of the Committee on Public Policy and Legislation, Dr. Dwight Murray; chairman of the Committee on Medical Economics, Dr. Fraser; chairman of the Committee on Associated Societies and Technical Groups, Dr. Grayson; the President, Dr. Morrison; President-Elect, Dr. Shipman; Dr. Lafe Ludwig and Dr. Frank MacDonald.

VICE-SPEAKER BAILEY: Thank you, Dr. Lum. And the motion is on the adoption of the report or this section? Have you finished the complete report? The adoption of this section of the report? All those in favor of the report say "aye." Opposed?

... There being no further discussion, the motion was put to a vote and it was unanimously carried. ...

VICE-SPEAKER BAILEY: It is adopted. Continue, please.

DR. VAUGHAN: Your committee has before it for consideration one resolution submitted by Dr. William L. Bender, San Francisco, Resolution No. 2, which you have before you. While the committee approves heartily of the principles of economy and the operation of California Medical Association which we believe is the objective of this resolution, we cannot agree that reduction of the allowance to officers for certain living expenses while on official business will amount to any substantial saving. At the time, it seems the uniform \$25 per diem for these officers is much easier and more suitable a method of disbursing; we therefore recommend that this resolution "Do Not Pass."

Mr. Speaker, we recommend the adoption of this portion of the report.

VICE-SPEAKER BAILEY: You have moved and seconded to accept this portion of the report. Dr. Bender?

DR. BENDER: Mr. Speaker, members of the House: I constructed and submitted this resolution with two purposes in mind; one savings, which I still be-

lieve will be the result of the resolution if it should be adopted; and the other is actually a treatment for all of those who serve in official capacity, away from home, the California Medical Association.

This resolution has been introduced impersonally with malice toward none; I assure you. The fact remains that the principle of paying the actual expenses of those of our representatives who are traveling already is in effect for all members of committees and for all employees of the California Medical Association and for employees of the California Physicians' Service, although the trustees and officers receive the same \$25 per diem. The previous resolution along this line which was so roundly defeated on Sunday was introduced before we received our \$251,000 deficit in the budget for the next fiscal year and it seems to me that any means of saving money might be a little more acceptable in light of the budget that has been submitted to us.

There are a number of extra calls on our resources. You had one resolution today directed towards the help of young men studying medicine and particularly those who are just out of medical school who are having quite a struggle to exist and to whom the temptations of closed panels is really very great. I want to point out a little precedent also in the matter of paying expenses of traveling representatives of constituent states of the medical associations. It is noted in another part from one of the polls (the second one which I mentioned on Sunday), this one of March 1954, in which returns were received from 49 associations—or rather from 48 and I do of course have the figures of the California Medical Association relative to the support of the delegates to the American Medical Association sessions. Those associations who pay the actual cost of travel, "no" 41 out of 49. Those who pay the actual cost of maintenance, "no" 24 out of 49. Those who pay a per diem for maintenance, "no" 14 out of 49; and the range varies from \$5.00 per diem in addition to the travel, expenses being paid to \$25 per diem.

There are three in that category in the \$25 per diem category; included there the California Medical Association. Of those 14 who pay the per diem the mean payment each day for expenses, room and meals, that is \$15. The average is \$12.50. Those who pay lump sums to include travel and maintenance pay anywhere from \$200 per meeting to \$500.

Washington State is high with \$500. It is remarkable that wealthy Texas pays only \$250 per delegate including travel and maintenance. Two states pay nothing, West Virginia—and only travel is paid by Alaska and Florida.

Pennsylvania pays the maximum of \$450 to San Francisco and Georgia for instance pays a total of \$200 to include both items for delegates attending on the East Coast whereas if they come to the West Coast they get \$300.

So you see as far as the other state medical associations are concerned, they are operating at a considerable lower schedule of financial support of their travel representatives than the California Medical Association is. It is noteworthy in view of the dis-

cussion of the Editor's salary on Sunday that the New York Medical Association was cited as paying a salary of \$7,200 a year to its Editor. That of course is high for the nation, but New York State gets a little more careful when they pay the traveling expenses of their delegates, and they are on an actual expenditure basis which my resolution recommends for both travel and meals.

We often speak on the waste and the inadequacy of operation of our governments and it is interesting to note that the United States Government, even under the New Deal and the Fair Deal, and still does pay actual cost of travel or six cents a mile if the individual drives his own car, and maintenance at the rate of \$9.00 per day. A colonel or any officer or any civil employee gets \$9.00 a day for his room and his board, and this from the big wasteful United States Government of ours which we were glad to see taken over by a very economic minded new Administration recently.

The State of California pays the actual travel cost and for maintenance; they pay \$5.50 a day for meals and \$5.50 a day for room, so I simply submit to you the facts that the California Medical Association is extravagant as compared with other comparable organizations.

Expenditures of this sort—I think that the quarter million dollar deficit budget means that we have got to start to tighten our belts just a little bit and be economical in the operation of the California Medical Association if we are going to remain solvent. If we actually spend this \$250,000 in the next fiscal year we will have used up a half or over half of the revolving fund we keep for that purpose. It is thought that we won't spend that money but in my opinion that is mostly wishful thinking and also that it has been stated that we probably won't have to keep the \$183,000 item relative to Mr. Waterson's program continued more than a year or two, but that again is wishful thinking. What we are in is a long-term battle and the one who fights the best consistently is going to win out.

So I submit it to you simply as a question of whether or not we who are here responsible for the solvency of the California Medical Association are going to operate our society on the basis of our emotions in which we like to be kind and nice to our fellow members or whether we are going to operate it on a sound business principle. Thank you.

VICE-SPEAKER BAILEY: Now, Dr. Vaughan, would you state what the committee recommendation was? Read the resolve, please.

DR. VAUGHAN: Our consideration was to leave it as we have it at the present time in operation, not to have it on the per diem.

VICE-SPEAKER BAILEY: Thank you. Then you recommend it do not pass, is that correct?

DR. VAUGHAN: That is correct.

VICE-SPEAKER BAILEY: All right. Is there further debate on this resolution?

A MEMBER: Question.

VICE-SPEAKER BAILEY: The committee recommends "Do Not Pass." All those in favor of "Do Not Pass" say "aye." Opposed?

... There being no further discussion, the motion was put to a vote and it was carried. ...

VICE-SPEAKER BAILEY: That portion of the report is adopted.

DR. VAUGHAN: Mr. Speaker, we recommend the adoption of the report as a whole.

VICE-SPEAKER BAILEY: We have the adoption of the report as a whole.

DR. LUM, do you want to say something?

DR. LUM: The adoption has been seconded?

VICE-SPEAKER BAILEY: The adoption has been seconded. If you will now discuss it, Dr. Lum.

DR. LUM: Before this report is adopted as a whole I would like to discuss the budget with you briefly for your better understanding. There are elements in it that you may wish to discuss.

On your budget sheet you see three lines of figures. Let's clarify it. The first, the budget 1953-54. The second column where it says estimated, that is estimated expenditures, 1953-54 up to July 1, 1954. That is why the word estimated is there. The third column that we are interested in now, proposed budget for 1954-55.

Under income, membership dues, \$470,000. This is based on dues at \$40 a year, \$3.00 of which is paid to CALIFORNIA MEDICINE, a requirement under postal legislation, \$470,000 in dues.

Second, your Annual Session brings in \$24,000 from rental of space to exhibitors.

Postgraduate programs, \$12,250.

Interest on short-term Treasury notes, \$3,500.

Miscellaneous items, \$2,700.

The total anticipated income of \$512,450.

Expenditures: Items 6, 7, 8, 9 and 10 are self-explanatory.

Item 11, you will note that there has been a raise in the budget over last year due to the increased activities of the California Medical Association in the Los Angeles area. It was necessary to enlarge the office, hence the increase in the budget item.

Items 12A and B remain constant practically.

Item 13 essentially constant; 14 constant.

Item 15, you will notice a drop, \$4,260 to \$480. Dr. George Kress received a pension from C.M.A.; of course with his passing that item is deleted. The \$480 is a pension to a clerk who was in the office for many years. This has been an item on the budget for a period of time.

Item 16A, constant; B, constant; C, constant; D, constant.

Meeting expenses, 17. Annual Session remains the same. Item B has been changed. For the last several years the alternates have been going to one meeting of the A.M.A. a year, either the Annual or the Interim Session. You will note that the estimated expenses this year were lower because one A.M.A. meeting, as you know, was in San Francisco. As a result of the action of the House of Delegates sending alternates to both the Annual and the Interim Ses-

sion each year this item has been increased to \$21,000, increased \$9,000.

17C remains the same. Student A.M.A. remained the same. I thought you might be interested in that. There are four chapters of the Student A.M.A. in California. The California Medical Association sends delegates from each one of these chapters back to their Annual Meeting in Chicago. This has been a very worthwhile expenditure.

Memberships and subscriptions represent no additional expense, simply a new heading. That refers to subscriptions of the C.M.A. due to State Chamber of Commerce, California Taxpayers League, a few other organizations of that type, and the subscriptions to certain journals necessary for the employees.

Number 19, which was unfortunately omitted in mimeographing through a clerical error the other day—\$183,000 of this is to implement the action you took this afternoon. I think you all realize it has been necessary to expand and activate aggressive constructive programs in voluntary health insurance. As you know, Mr. Rollen Waterson has been retained to direct that service.

Mr. Speaker?

VICE-SPEAKER BAILEY: Yes, Doctor?

DR. LUM: I would like to ask permission of the House of Delegates for Mr. Waterson to discuss briefly the program.

VICE-SPEAKER BAILEY: Dr. Lum, if there be no objection from you we could continue with the rest of this report and get it out of the way. Then we could have Mr. Waterson.

DR. LUM: All right.

Number 20, miscellaneous expense, simply a basket for small items in which there is no other proper category.

Scientific, Education and Public Relations.

Item 21, Cancer Commission, \$29,415, approximately \$1,000 increase over the budget of last year. Blood Bank Commission, \$10,000.

Postgraduate Committee, \$28,000. I would draw your attention to the fact that under income you see there is anticipated income of \$12,250 from this program so that your net would be \$28,000 minus \$12,250 income.

Medical Services Commission, \$15,000.

The Committee on Unlawful Practices has no need at the present time for any expenditure of money. Thank the Lord we have one item of zero.

Number 26, Medical Education, \$100,000. I am sure you all know the plight that medical schools, particularly private medical schools, find themselves in. The American Medical Education Foundation has been organized to assist them financially. Several years ago if you recall California Medical Association gave them \$100,000 to initiate their activity. During the past year there has been a drop in donations from California. Dr. Murray tells us that in a conference with President Eisenhower, President Eisenhower told Dr. Murray and Dr. Martin whom most of you heard yesterday, in substance, "I believe in free enterprise. I do not want to see Federal aid to medical schools. That is the responsi-

bility that the medical profession must assume. If it does not, something else will be done."

That something else means Federal subsidizing of medical schools.

Item No. 27—Before we pass that, may I say that if the House of Delegates accepts this that this \$100,000 will go to the American Medical Education Foundation specifically earmarked for private schools. I said that the donations of the California physicians had dropped. I would like to quote a telegram received from Hiram W. Jones, American Medical Education Foundation, yesterday:

"Two hundred twenty California physicians gave \$16,342.50 to AMEF in 1953. Medical schools reported direct contributions totaling \$54,103.50, from 2,105 California physicians.

"I am sure we realize there are physicians who have given the medical schools funds which those schools have not reported to the AMEF so that the voluntary contributions would be somewhat larger than this \$54,000 quoted."

From California for the first quarter of 1954 are 217 contributors giving \$10,000. The Council certainly urges that the California Medical Association do its part. This can be done either through a compulsory assessment which I am sure none of us would agree to, through a contribution of this nature from the California Medical Association or through a voluntary contribution, and to date the system of voluntary contributions has fallen flat.

On with the budget, Item Number—

VICE-SPEAKER BAILEY: Dr. Lum, may I interrupt you for just a moment. There seems to be comparatively little difference in the rest of the budget from last year; unless anyone wants to hear it read, the Chair would propose to consider three items. One is a \$188,000 item for organization expense. The other, this \$100,000 item, and the third is reconsideration of the action we took two days ago making it compulsory that alternates and delegates be sent to the A.M.A.

DR. LUM: Mr. Speaker, before you do that—

VICE-SPEAKER BAILEY: Go right ahead. I simply suggested—

DR. LUM: One point, I agree with you some of these are routine items. You will note that there is a deficit budget of \$265,845. You wonder how that shall be paid. The California Medical Association has \$465,000 in its treasury in short-term Treasury notes. Half of that will be required for the expenses of the Association until January 1, 1955. It is quite within reasonable expectation that any deficit budget could be paid out of that surplus. I want to bring out this point, this is not invading on the sanctity of the war chest. That money is held by the Trustees of the California Medical Association. This deficit budget would not remove one penny from that.

VICE-SPEAKER BAILEY: Thank you, Dr. Lum. Then it is in order for us now to ask Mr. Waterson, with the unanimous consent of the House, to speak

on the \$188,000 payment here for organization expenses. Mr. Waterson. Is Mr. Waterson here?

DR. LUM: Here he is.

VICE-SPEAKER BAILEY: Point of order here. Did I hear unanimous consent of the House? We didn't hear any objections. All those in favor of hearing Mr. Waterson will say "aye." Opposed?

... There being no discussion, the question was put to a vote and it was unanimously carried. ...

VICE-SPEAKER BAILEY: We hear unanimous consent. We might have had to recess otherwise. Mr. Waterson, please proceed.

MR. WATERSON: Mr. Speaker, members of the House of Delegates of the California Medical Association: You have this afternoon taken all of the action you could and should in order to meet the public desire for greater certainty of coverage under health insurance. That problem of course was the first to be solved and now we are discussing the means of implementing it.

We have been retained by the Council of the California Medical Association to achieve that. I am purposely here to discuss the budget but I need to describe to you very briefly the character of the campaign of the program that we intend to conduct and some of the problems in order for you to understand how we arrived at that figure.

We could not budget accurately. This is a fluid, constantly changing, dynamic field. We don't know what is going to happen tomorrow or what will happen the following day. Furthermore, the type of action that you took allows for, very properly, local option in every respect. And local activation. We have no ideas what counties will go in which direction at this time, what plans will be adopted, what will be required. But everything that we do will be under the direction of the local county society, to be inherently a local problem and work completely in cooperation with that society. But I want to repeat that it is impossible for us to tell at this time how many societies will act on which plans and what the problems will be. So that therefore we have budgeted a great deal more than we think we will need in order to meet contingencies, in order to meet emergencies, and I am sure that you can well imagine what some of these emergencies may be.

If, for example, a great deal of advertising is required in Los Angeles County the cost of proper coverage there is \$370 per inch of advertising space. If 100 inches are required in a single ad in the judgment of the doctors in that area and approved by the Executive Committee of the California Medical Association, that 100-inch ad would alone cost \$37,000. In some of your smaller societies you can get coverage for a dollar an inch as against this \$370 per inch.

This budget therefore should be considered as maximum figures. Again something to be used as needed, but it is not our plan to go into a great deal of paid advertising, to use it only as needed, to set up safeguards throughout the entire budget on this, providing that monthly budgets will be given by us to

the Executive Committee of the California Medical Association in advance and all major expenditures will be approved in advance by the Executive Committee of the California Medical Association. It is not our policy to go into the shotgun type of campaign. The work that we want to do here will, and that you will have permitted and authorized by your action today, is the type that will achieve public approval by the action itself, and I don't believe that a great deal of expenditure of funds for advertising is going to be necessary although you know that when you do things in the public interest, as you are doing them, the publicity comes of itself and that is our usual method of operation.

However, for our public education job, with eleven million people in California to contact, we will need additional personnel. We will need to use some of the media this budget includes for personnel and projected advertising. All of our progressive work has been carefully integrated with the Public Relations Department. There is no overlapping. Things that are budgeted for in the Public Relations Department budget are not budgeted for here.

Under the direction of the Medical Services Commission there is a great deal of work to be done in professional education on medical economics, on health insurance, on the Usual-Fee Plan, on the implementation of your action regarding the Usual-Fee Indemnity Plan this afternoon. That also will require aid, educational aids, printing and additional personnel. It will require meetings, in order to follow your orders; it will be implemented as rapidly as possible, we will need to bring chairmen of committees and officers of the county societies together in the very near future to outline in detail what the Usual-Fee Plan means, how it is to be implemented and how it could be implemented in each county. And in having done this we need to tell the public what we have done. It is also an item for consultation and research.

We may and probably will need consultants in a number of deals. Market analysts, perhaps, and layout experts, perhaps labor relations consultants, a number of things; actuaries, insurance consultants and others that we may need in order that our work will be best directed and in order to meet the specific problems that arise in each county.

As you understand, each county medical association as it embarks upon a program either of the raised income ceiling or of the Usual-Fee Plan or both requires a great deal of work in organization and planning, and also later in publicity and in selling, tailoring the actions of the insurance that can be sold in that local situation. Also, under this item is research. All of you know who operate in those areas where the closed panel plans operate that many patients pay their premium to the closed panel plan and yet go to their personal physicians for care at their own additional expense. We want to do research and see the extent of this. We want to be able to know how much this adds to the total cost of health insurance to the people who buy these plans so that the seemingly lower cost—I am sure will be

balanced and I am sure that all of you who operate and practice in these areas where there are closed panel plans know that this amount of money is an enormous one.

We also want to know something about doctor-patient relationships under various types of health insurance, about the incidences of malpractice, about the quality of medical care. These things are also covered under this project.

I want to reiterate the fact that we have a positive program or that you would have taken the action now so that we can sell people on insurance that will really be ready for certain coverage. However, we have certain intangibles to sell and intangibles are very difficult to sell. The concept of free choice of physicians has not yet been sold. I am sure that almost all of you are aware of this.

We need to tell people that it isn't only the choice of doctor that is important, it is the freedom to change. We need to tell them something of the problems of people who have gone into a closed panel plan, then want to go to their own personal physician are not then free to change to go to their own doctor without paying the entire cost and the loss of the protection for which they have paid. This concept needs to be told to them.

We also have this problem of incentive under the closed panel plan. It is obvious to all of you that the incentive of the closed panel plan is to withhold, to cheapen, to shorten that in medical care as compared to the incentive of the doctor of medicine in private practice to give care and to bring to his patient the best that there is in medicine. These are abstract things and difficult to sell and we will need all of your help in so doing.

Furthermore, your Medical Services Commission has asked that we do a great deal of work on the concept of the personal physician. This is of course one of the principal things that we have to sell. There is a great deal of education within the profession that needs to be done on how to demonstrate to patients the values of having a personal physician and a great deal of work that needs to be done with the public. We also have a problem of integration. Integration of California Physicians' Service, the Unlawful Practices Committee, the hospitals, the pharmaceutical associations, everyone else who is interested in this problem.

Finally you must remember that the stakes here are enormous, that we must not fail to do well during our first year to establish a good foundation for what will certainly be a long-range program.

I would be remiss in my responsibility to you if I did not budget enough to do the entire job that might be needed. However, as I have said before, we have budgeted a great deal more than we think we need. We think that your actions today and the subsequent actions of the county medical associations in implementing whatever plans to meet this public need or whatever actions they take are sufficient to win the battle in which we are now engaged.

Thank you very, very much.

VICE-SPEAKER BAILEY: Thank you very much, Mr. Waterson. (Applause.)

I believe it is fair for the Chair to state that there has been a tremendous amount of discussion on this and it has been very thoroughly studied and we are going to continue to do so. There being no further discussions of this particular item, I should like to go to Dr. Olney to discuss A.M.A. Delegates. Dr. Olney. That is item 17B.

DR. OLNEY: Mr. Speaker, I was one of the persons who voted in the affirmative on the amendment to send the alternates to the A.M.A. Inasmuch as there was a great deal of confusion on this issue in that the intent was to give the alternates experience with the A.M.A., but what's happened? It was not the intent that the Council should be directed to send all alternates to all meetings of the A.M.A.

I should like to move for reconsideration of this issue.

VICE-SPEAKER BAILEY: It is moved to reconsider and it is in order at this time. Is there a second to it? There is a second. Any further debate on the motion to reconsider?

If there is no further discussion, all those in favor to reconsider will say "aye." Opposed?

... There being no further discussion, the motion was put to a vote and it was carried. ...

VICE-SPEAKER BAILEY: The "ayes" have it and the motion is appropriately reconsidered. Will you state the question, Dr. Olney, that you wish reconsidered?

... Discussion off the record. ...

DR. OLNEY: I move that the alternates be sent to the A.M.A. at the discretion of the Council.

VICE-SPEAKER BAILEY: Is there a second to that motion?

A DELEGATE: Second.

VICE-SPEAKER BAILEY: Is there any discussion?

A DELEGATE: Question.

VICE-SPEAKER BAILEY: All those in favor will say "aye." Opposed?

... There being no further discussion, the motion was put to a vote and it was carried. ...

VICE-SPEAKER BAILEY: The motion is carried. The Council will make the decision.

Does anybody have any further points that they would like to discuss in the budget?

DR. GRAYSON (Sacramento): I would like to discuss Item 26.

VICE-SPEAKER BAILEY: Item 26 is Medical Education, \$100,000.

DR. GRAYSON: It seems that this is merely an alternative method of trying to accomplish the same thing that was attempted a year ago when an action was proposed to add \$25 to our C.M.A. dues. The pros and cons of that subject were discussed thoroughly and the \$25 addition was rejected. Again, this is merely another method of accomplishing the same purpose and it would appear that there is considerable compulsion in this method. Certainly we

would seem selfish if we were to say that we did not want to give \$100,000 for medical education. However, at this time we have approved an expenditure of almost twice this much for medical organization, that is for ourselves. However, we have approved expenditure of that money for our successors. We are guaranteeing them the type of practice that we ourselves desire, so we are spending that money for our successors and their assistants.

In order to save time and to bring this as rapidly as possible to a conclusion, I would move that Item 26 be stricken from the budget.

VICE-SPEAKER BAILEY: Dr. Charles Grayson of Sacramento has moved that Item 26, Medical Education, \$100,000, be deleted from the present budget. Do I hear a second?

... The motion was variously seconded. ...

VICE-SPEAKER BAILEY: The Secretary says that we have already accepted this report but I can't believe that a thing such as this should go before the House without debate to be considered. Is there a second to Dr. Grayson's motion?

A MEMBER: I second.

VICE-SPEAKER BAILEY: There is a second. Further debate on this item for \$100,000 for medical schools. Dr. Cline. I feel that we should reconsider this before we reconsider Item— Do you wish to reconsider it? The budget was passed in the first part of the report. The Speaker didn't realize that or he would have allowed debate on it previously and he still feels it is important to have further debate. Does anyone object to it? Please proceed.

DR. CLINE: I am afraid I am a little confused. Am I speaking to an active motion or to an accomplished fact?

VICE-SPEAKER BAILEY: You are speaking to the motion to delete the item of \$100,000.

DR. CLINE: Mr. Speaker, does not that require the reconsideration of the prior motion to accept the budget?

VICE-SPEAKER BAILEY: There seems to be no objection to asking it now. I asked the House just a moment ago.

DR. SHERMAN: Point of order, sir. I believe in order to discuss this now we should have a motion to reconsider this item on the budget of Item 26.

A DELEGATE: So moved.

DR. SHERMAN: And I so move.

VICE-SPEAKER BAILEY: It is moved and seconded that we reconsider this particular item on the budget, Item 26. I take it that the man who made the motion voted for the previous motion.

All those in favor of reconsideration of Item 26 in the budget will say "aye." Opposed?

... There being no further discussion, the motion was put to a vote and it was lost. ...

VICE-SPEAKER BAILEY: The "noes" have it. There is no further discussion.

Dr. Vaughan.

DR. VAUGHAN: Mr. Speaker, I move we adopt the report as a whole as amended.

VICE-SPEAKER BAILEY: There is a motion to adopt the report as a whole as amended before the House. Discussion? All those in favor will say "aye." Opposed?

... There being no discussion, the motion was put to a vote and it was unanimously carried. ...

VICE-SPEAKER BAILEY: So ordered.

...The Chair was assumed by Speaker Charnock....

SPEAKER CHARNOCK: That brings us down, gentlemen, to some unfinished business. This morning there was a challenge to the election from the Third Councilor District. The Qualifications Committee consisting of the President, President-Elect and one Delegate from the Councilor District involved met and they will give their report. And I remind you that under Article III, Section 11 of the Constitution of the California Medical Association, if the committee reports in favor of the nominee's election the Speaker shall declare him elected. If the committee reports against confirming the nominee's election a three-fourths affirmative vote shall be necessary to sustain the report of this committee.

Dr. Green, the chairman of the committee, will please report on the action of the Qualifications Committee.

PRESIDENT GREEN: Mr. Speaker, members of the House: Your Qualifications Committee reports in favor of confirming the nominee's election. (Applause.)

SPEAKER CHARNOCK: It is the duty of the Speaker to declare Dr. Clifford Loos elected Councilor for a three-year term from the Third District comprising Los Angeles. Due to a mix-up in voting this morning there is a question regarding the election of Dr. Loos as alternate delegate to Dr. Askey. In this respect Dr. Loos has asked the privilege of the floor.

DR. LOOS: Mr. Speaker and members of the House: I can't tell you how grievous it is to me to see discord and disharmony in this organization. I cannot feel that this disharmony in regard to me—I believe it is true enough to say this is not because of myself, it is because of the medical organization of which I am a member. Dr. Sampson wanted me to make a statement which I am glad to do. It is reiteration of a policy that I have maintained for twenty-five years and that is that we will never in any group of people have our service—my organization—an exclusive matter that they have to take it or else, that there is no solicitation in any way nor will there be. You want to realize that my organization has the approval of A.M.A. It has had it for a number of years. It is inconceivable to me that through chicanery or deceit on my part that the A.M.A. would have accepted my organization if it had capitation or solicitation or advertising. The A.M.A. doesn't stand for such things.

I consider that my organization is no more a closed panel than any group of doctors is. It is free and open, for every subscriber I have has signed his

name that he wants to become a subscriber. You want to realize that there is a demand for, say, so-called closed panels. Some people want that. I think it is far better that an organization that is run ethically and adheres to those policies is allowed to exist than otherwise.

In order to stop all of this discussion and disharmony about this matter of this alternate delegate to Dr. Vincent Askey, Mr. Speaker, I wish to withdraw my name as a candidate. And furthermore, in this connection I wish to nominate for the position as alternate delegate to Dr. Vincent Askey, Dr. Don Charnock. Thank you. (Applause.)

SPEAKER CHARNOCK: The question of alternate to Dr. Vincent Askey is open and a certain character, Dr. Charnock, has been nominated. Are there any further nominations for positions of alternate delegate to Dr. E. Vincent Askey?

A DELEGATE: Move the nominations be closed.

DR. ASKEY: Mr. Speaker, I wish to rise here to second the nomination of Dr. Charnock. That is the parliamentary procedure by which I gained my stand here. What I want to say is this, gentlemen, ever since I knew anything about the profession of medicine, doctors have been trained to consider the welfare of the patient and the welfare of their profession, and today I have seen another example of a true physician being willing to submerge his desires to what he considers probably the best of medicine, the best interests of medicine.

I may state this, that the California Medical delegation to the American Medical Association has always tried to uphold the best interests of the patient and the profession of medicine and I have never seen a man of your delegation who did not submerge his interests to that of your interests and the patient. I have followed and have seen Cliff Loos do that for I think it is about eight or ten years now. The fact that he has made this move makes me proud of him, and the fact that he has voluntarily withdrawn rather than cause any disunity in the California Medical Association I think entitles him to our respect and our thanks and our admiration. (Applause.)

...The Chair was assumed by Vice-Speaker Bailey....

VICE-SPEAKER BAILEY: Thank you, Dr. Askey. Are there further nominations for this position?

A DELEGATE: Move they be closed.

A DELEGATE: Second.

VICE-SPEAKER BAILEY: It has been moved they be closed. Will you vote by acclamation or secret ballot? Acclamation. All those in favor of Dr. Charnock will say "aye." Opposed?

... There being no further discussion, the motion was put to a vote and it was unanimously carried. ...

VICE-SPEAKER BAILEY: Dr. Charnock, I am very happy to declare you elected.

...The Chair was assumed by Speaker Charnock.... (Applause.)

SPEAKER CHARNOCK: Thank you. Is there any further unfinished business, Mr. Secretary? There is no further unfinished business.

Under new business, Dr. Justin Stein has asked for the floor. It will only take one moment, Dr. Stein.

DR. STEIN: Mr. Speaker, members of the House of Delegates: The Committee on Military Affairs and Civil Defense met this morning and we have a resolution which we consider is urgent. It is very short and it is non-controversial and I would appreciate the floor to present this resolution.

SPEAKER CHARNOCK: Is there any objection to Dr. Stein, who is the chairman of the Committee on Military Affairs and Civil Defense, putting forth a resolution on that ground? The Chair hearing none, go ahead, Dr. Stein.

DR. STEIN:

"WHEREAS, The present law governing Civil Defense expires June 30, 1954, and there is great need for reorganization; and

"WHEREAS, For many years there has been confusion regarding Civil Defense, lack of adequate planning, policy making and information to the public; and

"WHEREAS, In view of the critical world situation in the light of recent developments, adequate security for the civilian population must be provided for; now be it

"Resolved, That there be established within the Department of Defense a Department of Civil Defense with equal status with the Departments of the Army, Navy and Air Force; and be it further

"Resolved, That the Department of Civil Defense be aided by a secretary who ranks equally with the Secretaries of the Army, Navy and Air Force; and be it further

"Resolved, That the chief operational officer of Civil Defense shall be a member of the Joint Chiefs of Staff; and be it further

"Resolved, That the California Medical Association Delegates to the American Medical Association be instructed to present a similar resolution at the next session of the House of Delegates of the American Medical Association."

Mr. Speaker, I recommend that this resolution "Do Pass."

SPEAKER CHARNOCK: Is there a second? It has been moved and seconded that this resolution "Do Pass." Is there any discussion? Are you ready for the question? All those in favor of the passage of this resolution will signify by saying "aye." To the contrary?

... There being no discussion, the motion was put to a vote and it was unanimously carried. ...

SPEAKER CHARNOCK: It is passed.

I have two important announcements to make. The C.P.S. Board of Trustees will hold its organizational meeting in Conference Room 9 immediately following the adjournment of the House of Delegates.

Second, the Council will meet for a reorganization in Conference Room 6 at 6:00 p.m. — Conference Room 2, they tell me.

Dr. Dave Dozier.

DR. DOZIER (Sacramento): I would like permission of the House to introduce as an emergency resolution a resolution pertaining to distribution of funds under the Medical Education item recently passed by this House in the budget.

SPEAKER CHARNOCK: Is there any objection to the hearing of this resolution? The Chair hearing none, go ahead, Dr. Dozier.

DR. DOZIER:

"WHEREAS, Funds distributed by the National Education Fund are equally divided among medical schools regardless of their particular needs; and

"WHEREAS, Our own private non-land-grant schools are each in need of all monies available; and

"WHEREAS, Land-grant medical schools in this state have been in the past adequately sustained by our Legislature; therefore, be it

"Resolved, That any fund contributed by the California Medical Association to the National Educational Fund be earmarked as restricted to non-land-grant schools of medicine located in California."

SPEAKER CHARNOCK: Is there a second to that?

A DELEGATE: Second.

SPEAKER CHARNOCK: It has been moved and seconded that money appropriated in this \$100,000 fund be earmarked for private schools in California. Is that correct, Dr. Dozier?

DR. DOZIER: Yes.

SPEAKER CHARNOCK: Is there any discussion to that?

DR. DOZIER: Mr. Speaker, under discussion might I simply point out to you that we have at the present time five medical schools in this state which are recognized as Class A schools. I, of course, am a graduate of Stanford Medical School, and as many of you know we have been having a very critically serious time in our medical school keeping it going the way we would like to have it going from the standpoint of finances. Stanford has carried on a campaign among its own graduates over the past two years or three years and we have now raised among our own graduates close to \$200,000. That is not all at once, of course, but total to date. For that, unless I am badly mistaken or misinformed, the National Education Fund has never taken cognizance and as a result of that California doctors stand today accused of contributing a very minimal amount of education, and as these funds have been broken down between the 74 or 78 medical schools in the country it means a really very small amount to each school.

As I understand further, the National Educational Fund doesn't make any great distinction between non-land-grant colleges or private colleges and land-grant colleges. Most of those of the latter have, as I pointed out, been fairly well taken care of by the Legislature. I don't mean in any sense to precipi-

tate any row between old rivals but I do think this House (laughter) could very well consider the applicability of these funds and where they best be spent.

SPEAKER CHARNOCK: Thank you, Dr. Dozier. (Applause.)

Dr. Cline wishes to speak on this resolution.

DR. CLINE: I do not rise to oppose this resolution. I wish to clarify certain points. The original principle of the American Medical Educational Foundation was that it would distribute its funds equally to all schools without any consideration as to need or as to their other means of financing. It did not desire to do so because it felt that there were schools which required more in the line of assistance than in others and certainly the private schools need that to a much greater extent.

More recently, if I am not mistaken, I am not a hundred per cent certain on this point and I wish you to understand that, I am not, but I believe I am correct that earmarked funds originally were simply assigned to that school by the donor but taken away—that other money was taken away from the general fund which might be available to the particular school to which it was assigned. I think that is no longer the case but now an assignment is a real assignment. All of the donations to medical schools are made through the National Fund for Medical Education which is an entirely different organization but which works very closely with the American Medical Educational Foundation. This is the organization which was the brain child of Ray Lyman Wilbur. It is headed as honorary chairman by Herbert Hoover.

President Eisenhower was an important factor in that organization before he became President of the United States. It is supported by industry and to date its contributions have been greater than those of the medical profession. I think that we should realize that the action taken today in appropriation of \$100,000 is a very sound action. I would say that if anything it is on the niggardly side.

The reason I say that is this, every man sitting in this room was educated partially at his own expense or that of his family, but to a much greater extent he was educated either by private philanthropy or the taxpayer. No one of us has ever, regardless of how much he has given to his own medical school, has ever contributed anything like the cost of his medical education to that school unless he has been an extremely unusual person. Our schools are in need. Whether Dr. Dozier's motion is wise or not, I think it is a matter for the House to decide. We are California doctors but there are many of the California doctors who are graduates of other medical schools. I think that they should be given some consideration in view of the fact that this money is being contributed equally by each member of the C.M.A., but I wish to correct just one or two items with reference to the contributions.

Originally we were unable to find out the money which was given directly to medical schools. Certain ones of them refused to divulge that information.

More recently they have seen the serious purpose and the real value of the American Medical Education Foundation and they have all, I believe as of the present time, agreed to and have reported the amount of money given by individual physicians directly to their schools, and I speak of this as an item of some shame because the total contribution in both categories was \$70,446 in 1953. I think that certainly is not a record of which the California physicians can be proud. Of that total \$54,000 odd dollars were contributed directly to the medical schools and about \$14,000 contributed through the American Medical Education Foundation.

Now I think that we have to consider lengthily what our responsibilities are in medical education. Dr. Grayson spoke at some length concerning what we were preparing for our successors. You have got to prepare the right basis of their succession. We have to realize that American medical education is the finest medical education which the world has ever known. We cannot allow it to slip from that high pedestal either because of lack of adequate support or domination by the Federal Government and I think that each one of you should consider ways and means in his own county society of increasing the voluntary contributions either directly or through the AMEF.

It doesn't matter so long as medical education gets those contributions, and I sincerely hope that you will encourage that effort because this is not a record of which California can be proud. And if you are unable to do so I think then it is thoroughly legitimate to consider that this Association might take appropriate action at some future time to insure that the doctors of this state do contribute their share to the institutions which gave them their educations and made it possible for them to be physicians.

SPEAKER CHARNOCK: Thank you, Dr. Cline. Is there any other discussion? Dr. Mauer.

DR. MAUER: This is a brief announcement. I think that this House of Delegates should know because it has received no publicity, that one of its members, the late Dr. Leo Levy, left the fortune of his family on his death a year or so ago. The estate was finally distributed in December of 1953 and he left somewhat in excess of \$450,000 to his medical school, Jefferson.

SPEAKER CHARNOCK: Thank you, Dr. Mauer. Is there any further discussion on Dr. Dozier's resolution?

A MEMBER: I know you all want to go home.

I too am a Stanford graduate and I am most interested in financial aid to perpetuate the finest school of medicine in the State of California. (Applause and laughter.) However, I see no point in making a very generous contribution of \$100,000 to the AMEF and take it out of one pocket and put it in one of our other pockets. I therefore oppose this resolution.

SPEAKER CHARNOCK: Any further discussion on this resolution? Dr. Daniels.

DR. DANIELS: Well, time is getting short certainly and we don't want to prolong this but a great deal of discussion took place on this item in the Council and it was felt—and for quite a little while many of us felt that it should be limited to the private schools in California. However, the suggestion came out that since Illinois has dues of \$20 a year tacked onto their state dues and just goes into the general fund, and other states have similar sums, though I can't exactly quote the other ones, but that is so about Illinois, that perhaps it might start a precedent if we instead of limiting the funds to the three private schools in California that this be appropriated to the private schools or the non-land-grant schools, whatever you wish to call them, of the United States with the thought that perhaps the other states may decide on giving contributions and might follow our example, Illinois perhaps might follow our example of limiting their donations to non-land-grant schools and not to the state supported institutions.

So I would like to amend this by striking out those last few words of Dr. Dozier's. I think just of the State of California would apply to the land-grant schools period—not of the State of California, the non-land-grant schools.

SPEAKER CHARNOCK: Is there a second?

A DELEGATE: Second.

SPEAKER CHARNOCK: There is a second to the amendment. Is there any discussion on the amendment, striking out the words "in the State of California" and making it applicable to all private schools within the United States of America?

A DELEGATE: Question.

SPEAKER CHARNOCK: Those in favor of the amendment will signify by saying "aye." To the contrary?

... There being no further discussion, the question was put to a vote and it was unanimously carried....

SPEAKER CHARNOCK: The amendment is passed. Now are you ready to vote upon the resolution as amended?

A DELEGATE: Question.

SPEAKER CHARNOCK: Those in favor of the resolution as amended will signify by saying "aye." To the contrary?

... There being no further discussion, the motion was put to a vote and it was carried....

SPEAKER CHARNOCK: It is passed.

At this time of the evening the only person who is on speaking terms with your new officers is Dr. Pete Green.

PRESIDENT GREEN: Mr. Speaker, members of the House: In coming to the microphone just now I just want to say two things or three very shortly. Firstly, I wish to thank all the members of this Association and all its officers, all the Board personnel and every person who in any way has contributed to the success of the administration. That includes our public relations officers who have done me a lot of good. I couldn't leave without saying

that. I am sorry that my term is over, there is much to be done.

At this time I should like to present to you Dr. Sidney J. Shipman, your President-Elect. Dr. Shipman of San Francisco! (Standing applause.)

DR. SHIPMAN: Thank you very much. I know that an incoming President or President-Elect can say nothing except that he will do his best. However, as retiring chairman of the Council I would like to say just one word in appreciation of those members of the Council who have served so loyally during the time that I have been serving. They have been a great bunch of fellows. It has been a real privilege to serve with them. The eastern medical politicians will never hold appropriate awe for me after knowing these members of the Council so well and the other members of the team. The staff have been uniformly kind and courteous during these years I have been chairman. I couldn't ask anything more from them.

Whenever I phoned Hap Hassard he laid down what he was doing and answered the phone, always helped me out, and Murph did the same thing, and Ben Read and the rest of the group that served with the C.M.A. It is a great team, fellows. Thank you. (Applause.)

PRESIDENT GREEN: The next person of your elected officers is Donald A. Charnock, whom you know. I just present him to you. Dr. Charnock, Speaker of the House! (Applause.)

SPEAKER CHARNOCK: Before the next meeting of the House we will finally resolve this argument, agendum versus agenda. Thank you. (Laughter.)

PRESIDENT GREEN: Thank you, Don.

Number three of your elected officers is a gentleman also from Los Angeles, Dr. Wilbur Bailey, your Vice-Speaker of the House. Dr. Bailey! (Applause.)

VICE-SPEAKER BAILEY: Thank you for your cooperation through thick and thin. (Laughter.)

PRESIDENT GREEN: And now, gentlemen, the man who assumes my mantle. Do you remember the old story years ago when we had Henry Rogers in here and somebody said, "Who are we going to elect to fill Henry Rogers' shoes?" Do you remember that? By golly, nobody could fill his shoes, they were so damn big! (Laughter.) But at this time I will turn my duties over to a gentleman that I know very well will do the job for you that you have chosen him to do, Dr. Morrison from Ventura, your President! (Standing applause.)

PRESIDENT MORRISON: Mr. Speaker: Last year, you remember, I took about one minute. This year I want to take just a few more.

I would like to say first that I too am sorry that Pete's term is expiring. It is nice now to get to the pleasant side of these things and so I would like to pass a few bouquets. First I would like to congratulate the House on your choice of the new President-Elect as I feel he is a very fine addition to the many illustrious men that we have had before your present Speaker. I would like to thank very much those county societies who have bulletins who have been

kind enough to send them to me. I think this is a very important thing for your officers and I have found them a valuable source of keeping up with what was going on over the scene.

Third, I would like to say a word about newspapers. In my travels over the state I have been treated very kindly by the newspapers as a matter of straight reporting. Despite all of the adverse publicity in national magazines et cetera I feel that bringing newspaper articles—they are beginning to give way to better understanding. I feel that many writers are accepting what I consider to be their moral responsibility in attempting to learn more about the problems in this field, and as they are doing a better job of reporting, as for example the recent affair in Los Angeles where there was some question about the type of cancer treatment. Which should be given?

Then I would like to repeat one thing that I have been saying in county societies and one thing which the doctor before me said who was out here, and that is to urge every doctor not only in this House but in the state to take a more active part in community affairs because that pays us great dividends in understanding, and I think also takes care of a very definite need in a service that we can render to the public. And also, I can assure you that the public appreciates it.

I would like to cite just one more example. In so citing I do not wish to disparage in any way the works of the chairmen of our committees who have spent so many hours, but just recently, whether you know it or not, Henry Randel, chairman of our World Health Committee, was cited by the State P.T.A. for the service of that committee. I am sure that Henry would be the first to tell you that he accepts that for all his committee members.

Now, in closing I think that we must continue to look forward, I think the thing we must do is to stress these positive policies which we sponsor for the good that will pay us the greatest dividends, and in closing I would again like to assure you that it is the earnest desire of our officers, and I know it is of the Councilors, to do what we feel is best for California medicine, and I can assure you that the thing uppermost in our minds is what is good for California medicine in all of our deliberations. Thank you. (Applause.)

SPEAKER CHARNOCK: At this time we will call upon Dr. Lewis Alesen, most recent Past President, to present Dr. Green's certificate for retiring President.

DR. ALESEN: Mr. Speaker: And Dr. Green, would you please come up here? It has been quite aptly said that there is nothing quite as dead as last summer's Romans. Also, to go along with that I would suggest we classify past presidents. However, there is some reason for hope because of this age of hormones, even Romans have been revived and continue to live on past the age of one hundred years. (Laughter.) So we may therefore give some hope to retiring past presidents.

John, you have done a wonderful job as President during the past year. We have known you over the years and have followed you throughout the Council, its various activities. I have been proud and happy to have been part of your work, to have known you.

However long I have been associated with you I have always found you to be a true friend of medicine. You have been a scientist, a scholar, a real scientific minded individual.

On behalf of the world's best and greatest and best known medical association, the California Medical Association, I want to give you this little plaque.

"Presented to John W. Green, M.D., in appreciation of his services as President, 1954."

... The plaque was presented to Past President Green. ...

(Standing applause.)

SPEAKER CHARNOCK: The Chair would like a motion for approval of the Minutes of the Committee.

A DELEGATE: So moved.

SPEAKER CHARNOCK: Everybody in favor signify by saying "aye." To the contrary?

... There being no discussion, the motion was put to a vote and it was unanimously carried. ...

SPEAKER CHARNOCK: Is there any further business to come before this House of Delegates?

A DELEGATE: Move we adjourn.

SPEAKER CHARNOCK: The Chair will entertain a motion for adjournment.

A DELEGATE: So moved.

SPEAKER CHARNOCK: All in favor go home.

... The meeting adjourned at 6:05 p.m. ...

In Memoriam

BENNING, HENRY M. Died in Santa Barbara, June 19, 1954, aged 50. Graduate of Columbia University College of Physicians and Surgeons, New York, 1929. Licensed in California in 1943. Doctor Benning was a retired member of the Santa Barbara County Medical Society, and the California Medical Association.

BOYD, ROBERT T. Died in San Francisco, May 6, 1954, aged 57. Graduate of the University of California Medical School, Berkeley-San Francisco, 1926. Licensed in California in 1926. Doctor Boyd was a member of the San Francisco Medical Society.

BRULL, ALADAR. Died October 17, 1953, aged 63. Graduate of Magyar Királyi Pázmány Petrus Tudományegyetem Orvosi Fakultasa, Budapest, Hungary, 1913. Licensed in California in 1935. Doctor Brull was a member of the Los Angeles County Medical Association.

CLEMONS, E. JAY. Died in Los Angeles, June 22, 1954, aged 76. Graduate of the University of Illinois College of Medicine, Chicago, 1902. Licensed in California in 1913. Doctor Clemons was a retired member of the Los Angeles County Medical Association, the California Medical Association, and an associate member of the American Medical Association.

CONZELMANN, FRED J. Died in Stockton, June 26, 1954, aged 78, of coronary artery disease. Graduate of the University of Michigan Medical School, Ann Arbor, 1905. Licensed in California in 1912. Doctor Conzelmann was a member of the San Joaquin County Medical Society.

COSGROVE, CLAIR P. Died in Los Angeles, June 29, 1954, aged 50. Graduate of Northwestern University Medical School, Chicago, Illinois, 1931. Licensed in California in 1931. Doctor Cosgrove was a member of the Los Angeles County Medical Association.

COX, EDWARD R. Died in Coalinga, June 8, 1954, aged 60, of coronary occlusion. Graduate of the College of Physicians and Surgeons, Los Angeles, 1917. Licensed in California in 1917. Doctor Cox was a member of the Fresno County Medical Society.

DOYLE, LEO W., JR. Died in Berkeley, June 28, 1954, aged 36, of acute hemorrhagic pancreatitis due to chronic pancreatitis. Graduate of Northwestern University Medical School, Chicago, Illinois, 1943. Licensed in California in 1945. Doctor Doyle was a member of the Alameda-Contra Costa Medical Association.

EBRIGHT, GEORGE E. Died in San Francisco, June 26, 1954, aged 81, of coronary artery disease. Graduate of the University of California Medical School, Berkeley-San Francisco, 1899. Licensed in California in 1899. Doctor Ebright was a member of the San Francisco Medical Society.

MCCARTHY, F. JUSTIN. Died in San Francisco, June 17, 1954, aged 67. Graduate of Stanford University School of Medicine, Stanford University-San Francisco, 1915. Licensed in California in 1915. Doctor McCarthy was a member of the San Francisco Medical Society.

MAHAN, LILLIAN G. BULLOCK. Died in El Cajon, March 27, 1954, aged 86, of chronic myocarditis. Graduate of the Eclectic Medical College of the City of New York, New York, 1895. Licensed in California in 1921. Doctor Mahan was a retired member of the San Diego County Medical Society, and the California Medical Association.

REMMEL, ALVA J. Died in San Francisco, April 30, 1954, aged 78. Graduate of the Cooper Medical College, San Francisco, 1905. Licensed in California in 1905. Doctor Remmel was a member of the San Francisco Medical Society.

SHAFFER, CARL J. Died in Huntington Park, May 29, 1954, aged 82. Graduate of the State University of Iowa College of Medicine, Iowa City, 1903. Licensed in California in 1917. Doctor Shaffer was a member of the Los Angeles County Medical Association.

SHAPIRO, NEWTON H. Died in San Francisco, June 20, 1954, aged 47, of coronary artery disease. Graduate of the University of California Medical School, Berkeley-San Francisco, 1932. Licensed in California in 1932. Doctor Shapiro was a member of the San Francisco Medical Society.

WELFIELD, SAMUEL E. Died in San Francisco, June 28, 1954, aged 65. Graduate of the College of Physicians and Surgeons of San Francisco, 1918. Licensed in California in 1918. Doctor Welfield was a member of the San Francisco Medical Society.

WHEELIS, JOHN M., JR. Died recently, aged 48. Graduate of Stanford University School of Medicine, Stanford University-San Francisco, 1932. Licensed in California in 1934. Doctor Wheelis was a member of the Los Angeles County Medical Association.

WILEY, HARRY J. Died in Huntington Park, June 10, 1954, aged 72, of coronary artery disease. Graduate of the University Medical College of Kansas City, Missouri, 1904. Licensed in California in 1915. Doctor Wiley was a member of the Los Angeles County Medical Association.

CALIFORNIA MEDICAL ASSOCIATION

Annual Meeting

SAN FRANCISCO

May 1-5, 1955

Papers for Presentation

If you have a paper that you would like to have considered for presentation, it should be submitted to the appropriate section secretary (see list on this page) not later than November 20, 1954.

Scientific Exhibits

Space is available for scientific exhibits. If you would like to present an exhibit, please write immediately to the office of the California Medical Association, 450 Sutter Street, San Francisco 8, for application forms. To be given consideration by the Committee on Scientific Work, the forms, completely filled out, must be in the office of the California Medical Association not later than December 1, 1954. (No exhibit shown in 1954, and no individual who had an exhibit at the 1954 session, will be eligible until 1956.)

SCIENTIFIC PAPERS

SCIENTIFIC EXHIBITS

PLANNING MAKES PERFECT

AN EARLY START HELPS

SECRETARIES OF SCIENTIFIC SECTIONS

ALLERGY Ben C. Eisenberg
2680 Saturn Avenue, Huntington Park

ANESTHESIOLOGY John P. Howard
2558 4th Avenue, San Diego 3

DERMATOLOGY AND SYPHILOLOGY . R. Raymond Allington
3115 Webster Street, Oakland 9

EYE, EAR, NOSE AND THROAT—

ENT Francis A. Sooy (Chairman)
490 Post Street, San Francisco 2

EYE Robert N. Shaffer
490 Post Street, San Francisco 2

GENERAL MEDICINE Roger O. Egeberg
Wadsworth General Hospital, Los Angeles 25

GENERAL PRACTICE Stanley R. Parkinson
326 G Street, Marysville

GENERAL SURGERY Lyman A. Brewer, III
2010 Wilshire Boulevard, Los Angeles 57

INDUSTRIAL MEDICINE AND
SURGERY Homer S. Elmquist (Asst. Secretary)
629 S. Westlake, Los Angeles 57

OBSTETRICS AND GYNECOLOGY George Judd
2010 Wilshire Boulevard, Los Angeles 57

PATHOLOGY AND BACTERIOLOGY . . . Orlyn B. Pratt
312 North Boyle Avenue, Los Angeles 33

PEDIATRICS Milo B. Brooks
1015 Gayley Avenue, Los Angeles 24

PSYCHIATRY AND NEUROLOGY Knox H. Finley
450 Sutter Street, San Francisco 8

PUBLIC HEALTH E. M. Bingham
130 South American, Stockton

RADIOLOGY Merrell A. Sisson
450 Sutter Street, San Francisco 8

UROLOGY Wilson Stegeman
1166 Montgomery Drive, Santa Rosa



WOMAN'S AUXILIARY

TO THE CALIFORNIA MEDICAL ASSOCIATION

MORE HONORS FOR CALIFORNIA

Californians continue to hold high offices in our National Auxiliary. At the Convention in June, Mrs. Carl Burkland of Sacramento, immediate past state president, was elected Constitutional Secretary of the Woman's Auxiliary to the American Medical Association, Mrs. Raymond Wayland of San Jose, also a past state president, is serving her second year as a member of the Board of Directors, and she was also elected to the Nominating Committee.

Two of our national presidents have been Californians: Mrs. James Fulton Percy of Los Angeles served in 1932-33, and Mrs. Ralph B. Eusden of Long Beach, 1952-53. Two other national presidents have subsequently become Californians by adoption: Mrs. George H. Hoxie of Missouri now lives in Berkeley, and Mrs. Rollo K. Packard of Illinois has made Sherman Oaks her home. Mrs. Arthur Nies of Orange has just completed two terms of very capable service as National Parliamentarian.

* * *

NURSE RECRUITMENT IS OUR MAJOR PROJECT

Another honor came to California at the recent Convention, with the appointment of Mrs. Leonard Offield of San Mateo as Western Regional chairman of Nurse Recruitment. Mrs. Offield is serving her third term as state chairman of this very important activity. During the past year, \$16,422.25 was supplied in loans and given in scholarships to student nurses by our county Auxiliaries. Our overall program of nurse recruitment, since its inception in 1949, has helped 337 young women to enter training, with loans and scholarships totalling \$55,166.

Many counties also sponsor Future Nurses' Clubs, which help the students to become familiar with the profession before actually entering training. Other projects include hospital tours, panel programs, and the showing of films on nursing to junior and senior high schools throughout the state.

* * *

6,000 HANDSOME BACHELORS?

The California Medical Association has about 12,000 members in 40 county medical societies; your Auxiliary has 5,583 members in 31 county auxiliaries. We know that many of those M.D.'s are women—but there must be nearly 6,000 handsome, eligible bachelors in the C.M.A. Surely we don't have that many married doctors whose wives aren't availing themselves of the privilege of becoming members of the Auxiliary! The picture is much the same on the national level—140,000 members in the A.M.A. and 66,000

in the Auxiliary. With your help, we could nearly double our membership.

* * *

IS TODAY'S HEALTH IN YOUR WAITING ROOM?

If it is, you belong to an exclusive minority; only 15 per cent of our physicians subscribe to *Today's Health*, yet it is the only nationally distributed health magazine officially sponsored by the medical profession. It was established by the American Medical Association in 1923, as *Hygeia*, and became *Today's Health* in March 1950.

The first request that the A.M.A. made of the Auxiliary, back in 1931, was that we further the sales of *Hygeia*. Since then, this has been one of our major projects, because we know this is one way of winning more and more friends for medicine. Positive health education means good public relations. Written in layman's language, *Today's Health* states with authority what may be expected from the various new drugs and new medical treatments, outlines new surgical procedures to prolong life, and exposes medical quackery and old superstitions. Such a magazine instills confidence in the medical profession, alleviates fear of prescribed treatment, and generally inspires greater cooperation between the patient and physician.

May we respectfully suggest *Today's Health* as a weapon to combat forces that are inimical to organized medicine—the quacks, the charlatans, the malcontents and professional do-gooders in the government, the socializers and bureaucrats who rely on public ignorance and public apathy as their best allies.

Under the direction of Mrs. Everett Stone of Riverside, State Chairman, our Auxiliary sold 2,400 subscriptions last year, including 473 gift subscriptions to schools, libraries, beauty parlors and other public places. We anticipate another year of progress under the chairmanship of Mrs. Samuel Gendel of Fullerton.

Incidentally, doctors, the subscription price is only \$1.50 per year instead of the regular \$3.00, if you subscribe through an Auxiliary member. Let's surprise the A.M.A. by raising that 15 per cent they quote, to 100 per cent in California! With your cooperation we can do it.

MRS. FREDERICK J. MILLER, *President*

NEWS & NOTES

NATIONAL • STATE • COUNTY

LOS ANGELES

The sixth annual **postgraduate assembly of Saint John's Hospital**, Santa Monica, will be held September 13, 14 and 15 at the Elk's Club in Santa Monica.

Guest lecturers from outside the state who are to appear on the program are: Emory D. Warner, M.D., professor of pathology, State University of Iowa College of Medicine; Philip J. Hodes, M.D., professor of radiology, University of Pennsylvania Medical School; Robert McNair Mitchell, M.D., associate in gynecology and obstetrics, Post-Graduate School, University of Pennsylvania; Frederick A. Collier, M.D., professor of surgery, University of Michigan School of Medicine; and Charles F. Wilkinson, Jr., M.D., professor of medicine, Post-Graduate Medical School, New York University.

Registration fee for the course is \$10. Members of the armed forces, residents, interns and medical students will be admitted without fee. Inquiries may be addressed to John C. Egan, M.D., director of the assembly, St. John's Hospital, Santa Monica.

A \$30,000 **student loan fund** has been presented to the University of Southern California School of Medicine by the K. Arakelian Foundation of Fresno, California, it was announced recently by Dr. Gordon E. Goodhart, dean. The fund will be available to students who need financial assistance to complete their education. The repayment of loans will make the Arakelian fund self-perpetuating. Arrangements for the School of Medicine to receive the grant were made by Dr. H. M. Ginsburg of Fresno and George A. Emersian, president of the Arakelian Foundation.

SAN FRANCISCO

Dr. John O. Haman of San Francisco was elected president of the American Society for the Study of Sterility at the tenth annual conference of the organization that was held in San Francisco immediately prior to the American Medical Association convention.

At the same meeting the national organization gave official recognition to the Western Section of the American Society for the Study of Sterility.

The latter organization held a scientific meeting in Palm Springs last December which had an attendance of 200. Dr. Sheldon Payne of Los Angeles, president of the Western Section, announced that annual meetings devoted to infertility studies will be held by this group each winter in the west. Membership is open to all those in the western states interested in infertility. Application to the Western Section may be made to Dr. M. James Whitelaw, Stonestown Medical Center, San Francisco.

Five distinguished physicians from other countries will be guest speakers at the 25th annual **postgraduate symposium on heart disease** to be held October 6, 7, 8, 1954, at

Larkin Hall in the San Francisco Civic Auditorium. They are Viking Olaf Bjork of Stockholm, Sir Russell C. Brock, London; Drs. Pedro Cossio and Manuel Rene Malenow, of Buenos Aires, and Dr. Horace Smirk of New Zealand.

Five Northern California Heart Associations will cooperate with the San Francisco Heart Association to present the program. They are the Alameda County Heart Association, Marin County Heart Association, Monterey County Heart Association, Santa Clara Heart Association and the San Mateo County Heart Association.

Registrations may be made through the San Francisco Heart Association, 604 Mission Street, San Francisco.

* * *

The California Division of the American Cancer Society will have a **cancer conference** Friday, October 1, 1954, between 2 and 5 p.m., at the Palace Hotel, San Francisco. E. M. Butt, M.D., will be chairman, and the topics and the speakers who will discuss them are as follows:

1. Recent Advances in Chemotherapy—Byron Hall, M.D., San Francisco.
2. Super-Voltage in Cancer Therapy:
 - (a) Theories and Advantage of Multimillion Voltage Therapy—Robert S. Stone, M.D., San Francisco.
 - (b) Results of the Use of Million-Volt Therapy—Charles Elbert Grayson, Sacramento.
3. Evaluation of Various Cytological Techniques—H. S. Aijian, M.D., Los Angeles.
4. Advantages and Limitations of Radical Surgery in the Treatment of Cancer—Ian Macdonald, M.D., Los Angeles.
5. Present Status of Serodagnostic Procedures for Cancer—Justin J. Stein, M.D., and Andrew H. Dowdy, M.D., Los Angeles.

* * *

A training program for personnel concerned with the **care of children with cerebral palsy**, under the direction of Dr. Luigi Luzzatti will begin at Children's Hospital, San Francisco, next September. It was made possible by a grant of \$21,368 received by the hospital from the United Cerebral Palsy Associations, the hospital announced. For the coming academic year funds are available for a maximum of six students. There will be two courses of five months' duration beginning on September 1, 1954, and February 1, 1955. Students will receive a stipend of \$750 during their training program.

* * *

Appointment of **Dr. David A. Rytand** as acting executive head of the department of medicine at Stanford University School of Medicine, effective September 1, was announced recently. Dr. Rytand will succeed **Dr. Arthur L. Bloomfield**, who will become emeritus professor of medicine.

Also announced was the appointment of **Dr. Phillip Hunt Wells** as associate dean of the school of medicine in charge of school development. His principal duty, it was said, will be to give administrative assistance to four committees formulating plans for the consolidation of medical school facilities on the campus at Palo Alto.

* * *

At the recent meeting of the American Medical Association in San Francisco **Dr. Edward C. Sewall**, formerly professor of otolaryngology at Stanford University School of Medicine, who has been retired for several years, was called upon to be the honorary chairman of the Section in Otolaryngology and Rhinology.

Three members of the faculty of the University of California School of Medicine, San Francisco, retired July 1. They are **Dr. Karl F. Meyer**, director of the Hooper Foundation; **Dr. Robert Wartenberg**, clinical professor of neurology, and **Dr. Michael Hobmaier**, associate professor of comparative pathology.

STANISLAUS

A new elementary school in Turlock is to bear the name of two of the town's family physicians who were chosen for the honor in recognition that they have "given unstintingly of their time . . . to help others." They are Doctors **Albert and Eric Julien**, 73 and 71 years of age, respectively, who still are in active practice.

In a contest to select a name for the school, their name was placed in nomination by Mrs. Wilbur F. Trent, who said, "I feel they should be honored while they are among us, not at some future date."

GENERAL

The second annual meeting of **Bureaus of Medical Economics** sponsored by county medical societies was held concurrently with the C.M.A. session in Los Angeles in May. Representing their respective bureaus were Mr. and Mrs. Joseph Donovan, Santa Clara; Mr. C. A. Catassi, Alameda-Contra Costa; Mr. John Carnes, San Diego; Mr. Boyd Thompson, San Joaquin; Mr. Bob Williams, Orange; and Mr. Walter F. Dickey, managing director of San Francisco's Society-sponsored bureau.

Discussion of mutual problems and exchange of information featured the two-day session. The directors of the bureaus concluded their meeting with a motion that C.M.A. be requested to include the yearly meeting of the bureaus on its official program so that interested physicians can plan to attend.

The **American Urological Association** has announced the opening of competition for its annual award of \$1,000 (first prize of \$500, second prize \$300, and third prize \$200) for essays on the result of some clinical or laboratory research in urology. Competition shall be limited to urologists who have been graduated not more than ten years, and to men in training to become urologists. The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Biltmore Hotel, Los Angeles, May 16-19, 1955.

Full particulars may be obtained from the executive secretary of the association, William P. Didusch, 1120 North Charles Street, Baltimore, Maryland. Essays must be in his hands before January 1, 1955.

The 14th annual **Japan Medical Congress** will be held at Kyoto, Japan, May 1-5, 1955.

Recently a new **improvised hospital for civil defense** purposes was put on display in Washington, D.C. It is a 200-bed unit, but may be used as a nucleus for much greater expansion. It may be set up so that there will be a triage room, shock treatment room, three operating rooms, x-ray and film developing facilities, laboratory and pharmacy. The equipment also lists instruments, cots, linen, drugs, auxiliary power units, etc. It is completely mobile, weighs approximately 13 tons packed, occupies 2,000 cu. ft. storage space and can be transported in one large van. It is esti-

ated that it can be set up in a school or other suitable building by 30 reasonably well-trained persons in four to five hours.

Twenty of these units are now on procurement by the State of California Office of Civil Defense. It is planned that these units will be stored near the critical target areas, but well outside the danger zones, the Civil Defense Office announced.

Awards totaling \$55,650 for support of **research on diseases of the heart and arteries** were made recently to four California institutions by the Life Insurance Medical Research Fund. The awards were as follows:

Mount Zion Hospital, San Francisco, for research by Dr. Ray H. Rosenman on the role of potassium in maintenance of the blood pressure, \$8,250.

Stanford University School of Medicine, San Francisco, for research by Dr. Emile Holman on cardiovascular disorders in relation to their surgical treatment, \$12,200.

University of California School of Medicine, Berkeley, for research by Dr. I. L. Chaikoff on the development and prevention of arteriosclerosis, \$26,400.

University of California School of Medicine, Los Angeles, for research by Dr. William G. Clark on neurochemical aspects of hypertension, \$8,800.

POSTGRADUATE EDUCATION NOTICES

UNIVERSITY OF CALIFORNIA AT LOS ANGELES

Three-day Symposium in San Diego: Highlights of Clinical Endocrinology, July 28; Use of Physical Medicine in General Practice, August 4; Problems in Anesthesia, August 11.

Fall Schedule:

Surgical Anatomy—September 8 to November 10, Wednesday evenings.

Fundamental Principles of Radioactivity—September 16, 1954, to July 7, 1955, Thursday evenings.

Evening Medical Lecture Series—September 27 to December 13, Monday evenings.

Dermal-Abrasive-Planing Techniques—September 29 to November 3, Wednesdays.

Three-Day Symposium in Riverside: Highlights of Endocrinology, October 13; Anesthesia, October 20; Peripheral Vascular Diseases, October 27.

Anesthesiology—November 4 to 5.

Dermatology—November 10 to December 15, Wednesdays.

Contact: Mrs. Margaret H. Griffith, Assistant Head of Postgraduate Instruction, Medical Extension, University of California, Los Angeles 24, California.

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

Conference on General Surgery

Date: September 13 through 17, all day, at Medical Center. This conference will be offered for the purpose of stressing the newer concepts, methods of diag-

nosis, treatment and techniques in surgery. Throughout the session emphasis will be placed on the diagnosis and treatment of malignant lesions. Instruction will consist of didactic periods, panel discussions, and actual operative demonstrations which will be televised from the operating room to the lecture hall. This program will be designed for general practitioners who are doing surgery. The class will be limited.

Conference on Fractures and Diseases of the Bone

Date: September 20 through 23, all day, San Francisco County Hospital. The program will cover the newer concepts, methods of diagnosis, treatment and techniques. There will be didactic lectures, panel discussions, and actual demonstrations of illustrative cases. The class will be limited.

Medicine for General Practitioners

Date: September 21 to December 7, Tuesday evenings, East Oakland Hospital, Oakland. This is a continuation course which is offered every year, with complete change of program and speakers. Class limited.

Evening Lectures in Medicine, Part I and Part 2

Date: September 16 through December 9, Thursday evenings, Mills Memorial Hospital, San Mateo. This is also a continuation course which will be of interest to both internists (Part 1) and to physicians in general practice (Part 2).

Symposium on Endocrine Diseases and Geriatrics

Date: October 22, 23, 24 (week-end), University of California Extension Building, 540 Powell Street, San Francisco. A review of recent developments in both fields, with suggestions for the management of patients past the age of fifty.

Contact: Stacy R. Mettier, M.D., Head of Postgraduate Instruction, Medical Extension, University of California Medical Center, San Francisco 22, California.

UNIVERSITY OF SOUTHERN CALIFORNIA

Dermatology and Syphilology—Beginning September 13, 1954. Fee: \$1,000.

This is a full-time course of twelve-month duration, carries thirty-two units credit toward the graduate degree of Master of Science, and is accredited by the American Board of Dermatology and Syphilology. It is designed for physicians who plan to take the examination for certification by the Board. Dr. Maximilian E. Obermayer is the course director. The course is presented only every third year and open to not more than twelve qualified physicians.

Intensive Review of Internal Medicine, Course No. 855—September 20 to October 1, 1954. Fee: \$50.00.

This course is designed primarily for students planning to take the examination of the American Board of Internal Medicine. Forty hours of didactic lectures, 8:00 a.m. to 12:30 p.m., Monday through Friday. It will cover the fields of Cardiology, Endocrinology, Gastroenterology, Hematology, Infectious Diseases, Renal Diseases, Arthritis, Nutrition, Neurology, and Isotopes. Enrollment limited to 50 students, applications accepted to August 15. Course director is Donald W. Petit, M.D. Gastroenterology, No. 844, beginning September 20, 1954, one year, full time. This is a full time course designed to give a limited number of qualified physicians advanced training in this field. Didactic courses will include intensive study of physiology and pathology

as well as the clinical aspects of the diseases of the digestive tract. Clinical teaching will be done in the out-patient department and on the wards of the Los Angeles County Hospital. Emphasis will be placed on the clinical approach using such diagnostic aids as sigmoidoscopy, peritoneoscopy and gastroscopy as indicated. Opportunities will be available to observe fluoroscopic examination, as well as the interpretation of the x-rays of each case. Director, George K. Wharton, M.D.

Contact: Robert S. Cleland, M.D., director, Medical Extension Education, University of Southern California School of Medicine, 2025 Zonal Avenue, Los Angeles 33, California.

Medical Dates Bulletin

THIS BULLETIN of the dates of postgraduate education assemblies and the meetings of various medical organizations in California is supplied by the Committee on Postgraduate Activities of the California Medical Association. In order that they may be listed here, please send communications relating to your future medical or surgical programs to: C. A. Broadus, M.D., 1036 North Center Street, Stockton 3, California.

SEPTEMBER

Sixth Annual Postgraduate Assembly, St. John's Hospital, September 13, 14, 15, 1954, John C. Eagan, M.D., Director, 1328 22nd Street, Santa Monica.

Tulare County Annual Postgraduate Meeting, Visalia, September 19, 1954, George D. Lavers, M.D., 204 North L Street, Tulare.

OCTOBER

American Cancer Society, California Division, Cancer Conference, Palace Hotel, San Francisco, October 1, 1954—2:00-5:00 p.m.

California Society of Internal Medicine, Yosemite National Park, October 2, Walter Beckh, M.D., 384 Post Street, Suite 603, San Francisco 8.

San Francisco Heart Association, 25th Annual Postgraduate Symposium on Heart Disease, October 6-7-8, Gladys Taylor Daniloff, 604 Mission Street, San Francisco 5.

Los Angeles County Heart Association, Annual Professional Symposium on Heart Disease, October 13-14, Mr. Robert Pike, executive director, 316 S. Bonnie Brae, Los Angeles.

San Diego County Heart Association, Annual Professional Symposium on Heart Disease, Friday, October 15, H. Jack Hardy, executive director, 1651 Fourth Avenue, San Diego 1.

California Academy of General Practice, Sixth Annual Scientific Assembly, Los Angeles, October 24, 25, 26, 27, Wm. W. Rogers, executive secretary, 461 Market Street, San Francisco.

NOVEMBER

Los Angeles Urologic Research Convention, Los Angeles, November 8-12.

JANUARY

American College of Surgeons, Palm Springs, January 21-22, 1955.

CALIFORNIA MEDICAL ASSOCIATION, Annual Session, San Francisco, May 1-5, 1955.

AMERICAN MEDICAL ASSOCIATION

Clinical Session, 1954, Miami, November 30-December 3.

Annual Session, 1955, Atlantic City, June 6-10.

Clinical Session, 1955, Boston, November 29-December 2.